U.S. Department of Labor

Office of Administrative Law Judges
11870 Merchants Walk - Suite 204
Newport News, VA 23606

(757) 591-5140
(757) 591-5150 (FAX)

Issue Date: 19 January 2007

Case No.: 2004-BLA-06363

IN THE MATTER OF:

B.S.,
Claimant,

v.

SWITCH ENERGY CORPORATION,
Employer,

and

KENTUCKY COAL PRODUCERS,
Carrier,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest.

APPEARANCES:

James P. Holliday, Esq.
For the Claimant

Rodney E. Buttermore, Jr., Esq.
Buttermore & Boggs
For the Employer

BEFORE: Daniel A. Sarno, Jr.
Administrative Law Judge

DECISION AND ORDER

This case arises from a claim for benefits filed under the "Black Lung Benefits Act," Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, at 30 U.S.C.

§ 901 *et seq.* ("Act"), and the implementing regulations at 20 C.F.R. Parts 718 and 725 (2006).[1] On February 8, 2006, a hearing was held in Hazard, Kentucky. Accordingly, the decision in this matter is based upon the testimony of Claimant at the hearing,[2] all documentary evidence admitted into the record at the hearing, and the post-hearing arguments of the parties, *except as specifically set forth in this Decision*.[3] The documentary evidence admitted at the hearing includes *Director's* Exhibits ("DX") 1 through 38,[4] Claimant's Exhibits ("CX") 1 through 5, Employer's Exhibits ("EX") 1 through 4, and Administrative Law Judge's Exhibit ("ALJX") 1.[5]

Overview of the Black Lung Benefits Program

The Black Lung Benefits Act is designed to compensate those miners who have acquired pneumoconiosis, commonly referred to as "black lung disease," while working in the Nation's coal mines. Those miners who have worked in or around mines and have inhaled coal mine dust over a period of time, may contract black lung disease. This disease may eventually render the miner totally disabled or contribute to his death.

Procedural History

On November 4, 2002, Claimant filed a claim for benefits. (DX 3.) Prior to filing this claim, Claimant had filed two other federal claims for benefits. The first claim was filed on April 1, 1987 (DX 1 at 59-289), and the second claim was filed on July 7, 1994. (DX 1 at 1044-47.) Claimant's first claim was denied by the district director on June 6, 1989 (DX 1 at 59-218), and thereafter administratively closed and deemed abandoned on August 22, 1989 (DX 1 at 59-292). Claimant's second claim was denied on September 18, 2001 when the Sixth Circuit Court of Appeals denied Claimant's petition for review. (DX 1 at 1-7.)

In addition to Claimant's prior federal claims for benefits, Claimant also filed a state workers' compensation claim in which Claimant was awarded benefits for his partial disability due to pneumoconiosis in a decision issued on July 11, 1986. (DX 8.) Thereafter, Claimant reopened his state workers' compensation claim, which Claimant subsequently settled by agreement dated July 5, 2001 and approved by court order on August 14, 2001. (DX 9-11.)

With regard to the current claim, on February 25, 2004, the district director issued his Proposed Decision and Order granting Claimant benefits. (DX 29.) Shortly thereafter, by letter dated February 27, 2004, Employer timely filed its Request for Hearing. (DX 30.) The case was

[1] The Secretary of Labor adopted amendments to the regulations implementing the Federal Coal Mine Health and Safety Act of 1969 as set forth in the Federal Register, 65 Fed. Reg. 79,920 (Dec. 20, 2000). These revised regulations became effective on January 19, 2001. *Id.* Accordingly, because Claimant filed his claim on November 4, 2002 (*DX* 3) the amended regulations are applicable in this case. Moreover, as Claimant last engaged in coal mine employment in the state of Kentucky, appellate jurisdiction of this matter lies with the Sixth Circuit Court of Appeals. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989)(en banc).

[2] The Transcript from the hearing is cited in this Decision as "TR" and by page and line number.

[3] See footnotes 22 and 30 herein

[4] Page numbers included in a citation are the page numbers assigned to the exhibit by the Director and not the original page numbers of the document(s).

[5] For the reasons set forth in this Decision, some of these exhibits, or portions thereof, were not considered in rendering this Opinion.

then referred to the Office of Administrative Law Judges for a hearing on May 28, 2004, and thereafter assigned to this office. (See DX 36.)

By Notice of Hearing and Order issued October 7, 2005, a hearing was scheduled to be held on February 8, 2006, in Hazard, Kentucky. At the hearing, exhibits were admitted into the record and the Claimant, B.S. testified. Also at the hearing, the Presiding Judge ordered that the record be held open until April 16, 2006 for the submission of post-hearing briefs. (TR 23:2-12.) In this case, Employer timely filed its brief.[6] Claimant, on the other hand, filed his brief out of time.[7] Notwithstanding this fact, because Employer did not object to Claimant's untimely filing of his brief and because the Presiding Judge finds that Employer will suffer no prejudice in this instance, Claimant's brief is admitted into the record.

Issues Presented for Adjudication

The following issues, listed as contested on the CM-1025 form, remain for resolution:[8]

1. Whether Claimant has pneumoconiosis;
2. If Claimant has pneumoconiosis, whether the condition arose out of Claimant's coal mine employment;
3. Whether Claimant is totally disabled;
4. If Claimant is totally disabled, whether Claimant's total disability is due to pneumoconiosis; and
5. Whether the evidence establishes a change in a condition of entitlement as required by 20 C.F.R. § 725.309(d).

(TR 5:19-23.)

Findings of Fact and Conclusions of Law

I. Factual Background

A. Claimant's Personal, Employment, Smoking, and Health History

Claimant was born on April 29, 1943. (DX 3.) He resides in Letcher County, Kentucky. (TR 10:16-20.) On April 9, 1966, Claimant married. (DX 12.) In this case, the parties have stipulated, and the Presiding Judge finds, that Claimant has one dependent (Claimant's spouse) for the purpose of augmentation. (TR 5:14-15.)

---

[6] April 16, 2006 was a Sunday. Employer's brief is dated April 17, 2006 and was received on April 21, 2006.

[7] Claimant's brief is dated June 16, 2006 and was received on June 19, 2006.

[8] At the hearing, the parties made the following stipulations: (1) the Claim was timely filed; (2) Claimant was a miner; (3) Claimant was employed as a miner after December 31, 1969; (4) Claimant is an eligible survivor of a miner; (5) Employer is the Responsible Operator; and (6) Employer has secured the payment of benefits. (*TR* 5:4-18.) After reviewing the record, the Presiding Judge finds that these stipulations are supported by the record. Additional issues are listed on the CM-1025 form as being contested by Employer for the sole purpose of appeal and are not addressed in this Decision. (*TR* 5:24-25.)

Claimant, who has an eighth or ninth grade education, made a living as an underground coal miner. (DX 23, p. 5:20-21; TR 11:13.) The parties have stipulated, and the Presiding Judge finds, that Claimant has *at least* ten years of coal mine employment. (TR 5:8-10.) In this case, the parties have also stipulated, and the Presiding Judge finds, that Claimant was required to perform heavy manual labor (TR 12:13-13:4). Specifically, as a miner, Claimant first worked as a joy loader and later as a scoop operator, which required Claimant to "clean up after a cutting machine and miners rock dusting." (DX 23 at 5:6:7-12 and 13:21-14:8; TR 12:4-9.) In Claimant's last coal mine position as a scoop operator, Claimant was also required to lift bags of rock dust and cement, build brattices, and move equipment such as motors for shuttle cars. (TR 12:13-25.) Claimant quit working in the mines after having a pacemaker implanted as treatment for a heart condition. (TR 16:24-17:2.) Although Claimant had returned to work after having the pacemaker implanted, he had to quit working because the machinery caused electrical interference with the operation of Claimant's pacemaker. (TR 17:3-8.) Claimant stated that he last worked in the mines in May of 1986 and has been on social security disability and workers' compensation for his heart and lung problems since that time. (TR 17:9-11; 21:4-22:25.)

At the hearing, Claimant estimated that he smoked for *approximately* fifteen years. (TR 19:3-7.) Claimant further stated that he quit smoking around 1983 or 1984 (TR 19:8-9) and that he smoked *approximately* half a pack a day (TR 19:10-12). On the other hand, Claimant claimed that he did not smoke this much consistently over the fifteen (15) year period (TR 19:13-16). Conversely, Claimant stated in his answers to interrogatories and in his deposition testimony that he smoked *approximately* three-fourths a pack a day from *approximately* the age of twenty to age forty and that he quit smoking in 1984 or 1985. (DX 23 at 19:10-16; DX 20.) Based on the foregoing, the Presiding Judge finds that Claimant smoked between one half to three-fourths of a pack of cigarettes per day for approximately twenty years.

Also at the hearing, Claimant testified that he is currently being treated by Dr. Bielecki, who is a general practitioner, and Dr. Alam, who treats Claimant for his respiratory problems. (TR 13:8-23.) Claimant stated that Dr. Bielecki is his "every day doctor" and that Claimant visits Dr. Alam, to whom Dr. Bielecki referred Claimant, approximately once a month. (TR 13:21-25.) Claimant stated that he has been prescribed a nebulizer, pills and inhalers by Dr. Alam. (TR 14:9-17.) Claimant testified that he has been treated by a lung doctor for approximately ten years, and that with the exception of an Advair inhaler, which has been prescribed for approximately the last two years, Claimant's medications have essentially stayed the same. (TR 18:14-25; 19:17-20:2.) Claimant stated in a deposition taken on June 25, 2003 that prior to Dr. Alam, Claimant's medications were prescribed by Dr. Bielecki. (DX 23 at 17:3-4.)

At the hearing, Claimant stated that he has not been hospitalized as a result of problems with his lungs or respiratory condition within the "last couple of years." (TR 14:18-20.) Yet, Claimant has been hospitalized for problems with his lungs or respiratory condition in the past. (TR 13:21-23.) Claimant had tuberculosis in the early sixties, which resulted in Claimant having to have surgery and have part of his left lung removed. (TR 16:14-22.) Claimant also had histoplasmosis once in the past, approximately ten years ago, for which he was hospitalized. (TR 17:21-18:9.) In his June 25, 2003 deposition, Claimant guessed that he had histoplasmosis in 1996, although he stated that he did not know for sure. (DX 23 at 23:24-24:3.) Claimant

testified that he has not had any other lung conditions other than tuberculosis and histoplasmosis. (TR 18:10-13.)

With regard to Claimant's current health, in addition to Claimant's back, heart, and lung problems, Claimant has high blood pressure and diabetes, which Claimant is not currently taking medication to control, although Claimant's condition is monitored by his physician every three months. (TR 20:8-25.) With regard to Claimant's respiratory condition, Claimant testified that he believed that his breathing problems would prevent him from returning to his previous coal mine employment. (TR 15:12-15.) Moreover, Claimant estimated that he could only walk approximately one hundred and fifty feet over level ground without running out of breath. (TR 15:16-18.) With regard to daily activities, Claimant stated that he does "[n]othing much" and that his breathing is so bad that he "can turn over in the bed and just about run[] plum out of breath." (TR 15:19-22.) In a deposition taken on June 25, 2003, Claimant stated that he does not drive and that he doesn't perform any tasks around the house, such as cutting the grass or taking care of the garden. (DX 23 at 27:17-28:1.) Conversely, Claimant's treatment records indicate that, at least at times, Claimant is able to perform some chores and yard work, as long as he paces himself. (*See, e.g.,* DX 16 at 9, 22, 31.)

II. New Medical Evidence

The new medical evidence in this case includes various chest x-rays, a biopsy report, pulmonary function studies, arterial blood gas studies, physicians' opinions, and hospitalization and treatment records, which are summarized below.

A. Chest x-rays

In a claim for benefits under the Act, a claimant must prove that he suffers from pneumoconiosis. One method by which claimant may establish that he has pneumoconiosis is by a preponderance of the chest x-ray evidence. The following chest x-ray reports are in the record:

Exhibit #/ Submitting Party/Purp.	*Name of Reader*	*Radiological Qualification*[9]	*Date of Study*	*Date of Reading*	*Film Quality*	*Sm. Opacities Reading*	*Sm. Opacities Shape/Size Prim./Sec.*	*Sm. Opacities Zones*	*Large Opacities*
DX 14 / / DOL Exam	Dr. Glen Baker	B	3/18/03	3/18/03	2	1 / 0	q / t	R (U/M/L) L (M/L)	B
DX 15 / / DOL Exam	Dr. Peter Barrett	BCR / B	3/18/03	4/14/03	2	Film Quality			
EX 2 / E / Rebuttal	Dr. Abdul Dahhan	B[10]	3/18/03	10/5/04	1	2 / 2	q / q	R (U/M) L (U/M)	O
CX 4 / C / Rebuttal[11]	Dr. Michael Alexander	BCR / B[12]	3/18/03	12/20/05	2	2 / 2	q / q	R (U/M) L (U/M)	A

[9] A "B-reader" ("B") is a physician, but not necessarily a radiologist, who successfully completed an examination in interpreting x-ray studies conducted by, or on behalf of, the Appalachian Laboratory for Occupational Safety and Health (ALOSH). 20 C.F.R. § 718.202(a)(ii)(E). A designation of "Board-certified" ("BCR") denotes a physician who has been certified in radiology or diagnostic roentgenology by the American Board of Radiology or the American Osteopathic Association. 20 C.F.R. § 718.202(a)(ii)(C).

[10] (DX 17.)

DX 17 / E / Initial	Dr. Abdul Dahhan	B	4/24/03	4/24/03	1	1 / 1	r / q	R (U) L (U)	O
CX 2 / C / Rebuttal	Dr. Michael Alexander	BCR / B[13]	4/24/03	10/4/03	2	2 / 2	q / t	R (U/M) L (U/M/L)	B
DX 18 / E / Initial	Dr. Gregory Fino	B	6/19/03	7/1/03	1	Neg.			
CX 3 / C / Rebuttal	Dr. Michael Alexander	BCR / B	6/19/03	10/4/03	2	2 / 2	q / t	R (U/M) L (U/M/L)	B
DX 16 at 42*	Dr. Wendell Gabier	Unknown (Doctor of Osteopathy)	1/3/03	1/7/03	Chronic fibrocalcific changes bilaterally and pleural plaquing through the right upper lung.				
DX 16 at 26*	Dr. Ashok Patel	Unknown	4/4/03	4/7/03	Fibrotic changes noted in both upper lobes and fullness with pleural thickening at the left apex. Fullness noted in right suprahila area. Mass in right upper lobe which cannot be excluded.				
CX 1 at 13*	Dr. Albert Berje	Unknown	4/8/04	4/9/04	Multiple calcified pleural plaques present in left lung. Oval shaped mass like opacity in right upper lobe noted. Chronic blunting of left costophrenic sulcus by pleural thickening.				

* These x-rays are part of Claimant's hospitalization and treatment records and are admissible pursuant to 20 C.F.R. § 725.414(a)(4). While these reports are in the record, they are not being considered for the purpose of establishing the existence of clinical pneumoconiosis under 20 C.F.R. § 718.202(a)(1), because they do not substantially comply with 20 C.F.R. § 718.102. On the other hand, as part of the record, these x-rays may appropriately be considered under 20 C.F.R. § 718.202(a)(4) for the purpose of providing some clinical basis upon which a physician may make a diagnosis of legal pneumoconiosis. *See* Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969, 65 Fed. Reg. 79,929 (Dec. 20, 2000).

B. Biopsy Evidence (CX 1)

Another method by which a claimant may establish that he suffers from pneumoconiosis is by a preponderance of the biopsy evidence pursuant to 20 C.F.R. § 718.202(a)(2). In order to be considered as evidence of pneumoconiosis under 20 C.F.R. § 718.202(a)(2), a biopsy report must substantially comply with the quality standards set forth in 20 C.F.R. § 718.106. Section 718.106 of Title 20 states that a report of "biopsy submitted in connection with a claim shall include a detailed gross macroscopic and microscopic description of the lungs or visualized portion of a lung" and that if "a surgical procedure has been performed to obtain a portion of a lung, the evidence shall include a copy of the surgical note and the pathology report of the gross and microscopic examination of the surgical specimen."

In this case, there is one biopsy report in the record, the report of Dr. Milton Skelly, whose qualifications are unknown. The biopsies analyzed by Dr. Skelly were collected by Dr.

---

[11] *See Spraugue v. Freeman United States Coal Mining Co.*, BRB No. 05-1020 BLA (August 31, 2006) (unpub.) (holding that a positive chest x-ray offered to rebut the positive x-ray interpretation provided in conjunction with the DOL sponsored pulmonary evaluation was rebuttal evidence because it responded to the case presented by the opposing party).

[12] (CX 3.)

[13] (CX 3.)

Mahmood Alam who performed a bronchoscopy on May 13, 2004. In his operation report, Dr. Alam made the following postoperative findings:

> Generalized deposition of anthrasilicotic pigmentation in both lungs. There is no stump on the left lobe. This appears to be clean. The left lower lobe has mild bronchostenosis. Also lingular segment has bronchial stenosis too. There was obviously not obvious endobronchial tumor on the right and left lung on detailed airway inspection. Generalized secretions were noted, especially in the left lower lobe area which was clogged up. A detailed pulmonary toilet was performed. BAL was performed and a biopsy was performed.

Following the bronchoscopy, Dr. Alam sent the biopsies for regular cultures and cytology. In a pathology report dated May 20, 2004, Dr. Skelly summarized his gross and microscopic findings and diagnoses after examining the six tissue samples and washings from Claimant's left lower lung. Based on his gross and microscopic findings, Dr. Skelly made the following diagnoses:

> Specimen A: Biopsy, lung, left lower lobe:
>
> 1. Fragments of alveolated lung parenchymal tissue with focal mild to moderate anthracotic pigment deposition and occasional macrophages.
> 2. Benign bronchial mucosa and submucosa with focal slight to mild chronic inflammation.
> 3. Malignant cells are not identified.
> 4. Fungal hyphae and budding yeasts are not identified on GMS stain.

C. Pulmonary Function Studies

In a claim for benefits under the Act, in addition to proving that he suffers from pneumoconiosis, a claimant must also prove that he is totally disabled. One method by which total disability may be established is through a preponderance of qualifying pulmonary function studies. To be qualifying, the regulations provide that the FEV_1 must be qualifying *and* either (1) the MVV or FVC values must be equal to or fall below those values listed at Appendix B of 20 C.F.R. Part 718 for a miner of similar gender, age, and height, or (2) the result of the FEV_1 divided by the FVC must be equal to or less that 55 percent. 20 C.F.R. § 718.204(b)(2)(i). The following pulmonary function studies are in the record:

Exhibit #/ Submitting Party	***Physician***	***Date of Test***	***age/height (in.[14]) coop/comp***	***Tracings/ Flow-Vol. Loop***	***Bronchodilator?***	***FEV_1***	***FVC/MVV***	***FEV_1/FVC***	***Qualifies?***
DX 14 / DOL Exam	Dr. Baker	3/18/03	59 / 68.75 Fair / Good	Yes	No	2.10	3.82 / --	54.97%	Yes[15]

[14] The Height used in this case is an average of the heights listed in the various pulmonary function studies: 69.442 inches.

[15] Based on FEV_1/FVC value.

DX 16 at 28 / C*	Dr. Alam	4/4/03	59 / 70 Data acceptable & reproducible	No –5 attempts were made	No	1.86	3.22 / --	57.76%	No
CX 1 / C*	Dr. Alam	4/8/04	60 / 70 Data acceptable & reproducible	No	No	2.09	3.09 / --	67.64%	No
CX 1 / C*	Dr. Alam	4/19/04	60 / 70 Data acceptable & reproducible	No	Yes	1.89 (2.05 post)	3.14 (3.37 post) / 79 (-- post)	60.19% (post 60.83%	Yes[16] (No post)
DX 17 / E	Dr. Dahhan[17]	4/24/03	59 / 68.9 Good / Good	Yes	Yes	2.19 (2.24 post)	3..36 (3.44 post) / 68 (69 post)	65.18% (65.12%)	No (No post)
DX 18 / E	Dr. Fino	6/19/03	60 / 69.0 Good / Good	Yes	Yes	2.18 (2.16 post)	3.47 (3.61 post) / --	62.82% (58.83% post)	No (No post)

*These pulmonary function studies are part of Claimant's hospitalization and treatment records and are admissible pursuant to 20 C.F.R. § 725.414(a)(4). Claimant designated the April 19, 2004 study as initial evidence in his case, yet the Presiding Judge notes that this study does not include three tracings and does not substantially comply with the quality standards set forth in 20 C.F.R. § 718.103. Accordingly, this study shall not be considered evidence of total disability under 20 C.F.R. § 718.204(b)(2)(i). For the same reason, the other two studies by Dr. Alam shall also not be considered as evidence of total disability under 20 C.F.R. § 718.204(b)(2)(i). On the other hand, these studies are admitted into the record and may be considered for other purposes.[18]

D. Arterial Blood-Gas Studies

Another method by which a claimant may establish total disability is through a preponderance of qualifying blood-gas studies under 20 C.F.R. § 718.204(b)(2)(ii). The following blood gas studies are in the record:

Exhibit # / Submitting Party	*Physician*	*Date of Test*	*Altitude[19] (feet)*	*Resting Exercise*	*PCO2*	*PO2*	*Qualifies?*
DX 14 / DOL Exam	Dr. Baker	3/18/03	0-2999	R[20]	36	87	No

[16] Based on FEV_1 and MVV values

[17] The MVV values obtained by Dr. Dahhan in his April 24, 2003 study, which do not substantially comply with the 20 C.F.R. § 718.103 quality standards, shall not be considered evidence of total disability under 20 C.F.R. § 718.204(b)(2)(i).

[18] For example, these studies may have been appropriately considered, in conjunction with other evidence, by a physician in formulating his opinions regarding Claimant's pulmonary health or these studies may be considered by the Presiding Judge for the purpose of determining whether other evidence or findings are consistent with the overall evidence of record.

[19] Although the elevations were not listed in three of the four studies, this omission is of no consequence because Claimant's results do not qualify under *any* of the elevations listed in Appendix C of 20 C.F.R. Part 718. Accordingly, the fact that these studies are nonconforming due to the omission of the physicians' failure to list elevation does not render these studies unreliable in this instance. Here the results are non-qualifying. Moreover, they are on par with the results obtained by Dr. Baker, whose study conforms with the quality standards set forth in the regulations.

DX 16 at 29 / C[21]	Dr. Alam	4/4/03	Not listed	R	39.9	76.3	No
EX / E	Dr. Dahhan	4/24/03	Not listed	R	36.1	80.8	No
DX 18 / E	Dr. Fino	6/19/03	Not listed	R	36.1	83.9	No

E. Medical Opinions[22]

In this case, the medical opinion evidence consists of the opinions of Dr. Baker, who performed the U.S. Department of Labor sponsored pulmonary evaluation, Dr. Dahhan, and Dr. Fino.

Medical Opinion (Report and Deposition Testimony) by Dr. Glen Baker (DX 16 at 57-62)

In a medical report dated March 18, 2003, Dr. Baker, who is a B-reader and is board-certified in internal medicine with a subspecialty in pulmonary medicine (*CX* 5 at 1:10-18), summarized his findings. In this report, Dr. Baker summarized Claimant's employment, family, medical, and social histories. Dr. Baker noted Claimant had a work history of seventeen years of underground coal mine employment and a past smoking history of around half a pack of cigarettes per day for approximately 21 years. Regarding Claimant's medical history, Dr. Baker noted that Claimant had tuberculosis in the early 1960's and for the last three to four years, suffered from wheezing attacks and chronic bronchitis. Dr. Baker also noted that Claimant, as of around May 1980, has heart disease and/or problems and high blood pressure. Moreover, Dr.

---

[20] Medically contraindicated due to degenerative joint disease

[21] The Presiding Judge has reviewed the arterial blood-gas study performed by Dr. Alam and finds that it is part of Claimant's treatment and hospitalization records and is therefore admissible under 20 C.F.R. § 725.414(a)(4) notwithstanding the evidentiary limitations set forth in 20 C.F.R. § 725.414(a)(2), *Dempsey v. Sewell Coal Co.*, 23 B.L.R. 1-47 (2004) (en banc), or the quality standards set forth in 20 C.F.R. § 718.105. The Presiding Judge notes that the quality standards set forth in 20 C.F.R. Subpart B of Part 718 apply only to evidence developed in connection with a claim for black lung benefits. *See* 20 C.F.R. § 718.101; Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969, 65 Fed. Reg. 79,928 (Dec. 20, 2000). Moreover, the Presiding Judge notes that no evidence demonstrating that the study is unreliable has been presented. The Presiding Judge finds that the study is reliable and that there is no basis (such as the study being performed during a hospitalization ending in the miner's death or that the miner suffered from a non-respiratory medical condition at the time the study was performed) for finding that the study does not represent Claimant's true lung function. *See* 20 C.F.R. § 718.105(d); *Jeffries v. Director, OWCP*, 6 B.L.R. 1-1013 (1984); *Hess v. Director, OWCP*, 21 B.L.R. 1-141 (1998).

[22] The medical report by Dr. Bielecki, dated September 19, 2003 and found in Director's Exhibit 19, is being excluded from the record because it exceeds the evidentiary limitations set forth in 20 C.F.R. § 725.414(a)(2) and does not substantially comply with the quality standards set forth in 20 C.F.R. § 718.104. In this case, the medical report by Dr. Alam, dated September 22, 2003 and found in Director's Exhibit 19, is also being excluded from the record because it does not substantially comply with 20 C.F.R. § 718.104: the report does not contain the results of a conforming chest x-ray or pulmonary function study and does not identify the specific medical tests relied upon by Dr. Alam. Additionally, the supplemental report written by Dr. Dahhan, Employer's Exhibit 4, is also being excluded from the record because it relies on medical evidence that is not in the record. Specifically, several of the hospitalization and treatment notes relied on by Dr. Dahhan in rendering his opinions are not in the record. Based on a review of the documents listed by Dr. Dahhan that have been admitted into the record, the Presiding Judge finds that these documents alone are insufficient to support Dr. Dahhan's opinions, so as to render his reliance on the unadmitted evidence inconsequential. Moreover, based on what Dr. Dahhan wrote in his supplemental report, the Presiding Judge is unable to determine if any of his opinions rely solely on admitted evidence. Accordingly, the Presiding Judge finds that Dr. Dahhan's supplemental report must be excluded in its entirety.

Baker noted that Claimant had part of his left lung removed due to tuberculosis and that Claimant received a pacemaker in 1986.

With regard to Claimant's present complaints, Dr. Baker noted that for approximately the last four to five years, Claimant has suffered from sputum, wheezing, dyspnea, and cough on a daily basis. Moreover, Dr. Baker also noted that Claimant complained of orthopnea for the last four to five years. During the physical exam, Dr. Baker noted that Claimant suffered from occasional wheezing.

Elsewhere in his medical report, Dr. Baker summarized the diagnostic testing conducted in conjunction with his physical examination and the results of those tests:[23]

Chest x-ray	Coal workers' pneumoconiosis 1/0 with B opacity, 1980 ILO
Vent Study (PFS)	Mild obstructive defect
Arterial Blood-Gas	Within normal limits
Other: EKG	Normal sinus rhythm, ST-T changes

In the cardiopulmonary diagnosis(es) section of his medical report, Dr. Baker made the following diagnoses: (1) based on Claimant's abnormal chest x-ray and coal dust exposure history, Claimant has coal workers' pneumoconiosis ("CWP") with progressive massive fibrosis ("PMF") with B opacity; (2) based on Claimant's history of cough, sputum production and wheezing, Claimant has chronic bronchitis; (3) based on the pulmonary function tests, Claimant has chronic obstructive pulmonary disease ("COPD") with mild obstructive defect; (4) based on Claimant's history, Claimant has old pulmonary tuberculosis; and (5) based on status post pacemaker, Claimant has sick sinus syndrome. In the etiology section of his medical report, Dr. Baker stated that he based his diagnoses on the following causes: (1) CWP and PMF with B opacity caused by coal dust exposure, although Dr. Baker questioned whether all changes might be secondary to tuberculosis; (2) chronic bronchitis and COPD caused by coal dust exposure and cigarette smoking; (3) old pulmonary tuberculosis caused by Claimant's tuberculosis; and (4) sick sinus syndrome possibly caused by atherosclerotic heart disease (ASHD). Moreover, Dr. Baker stated that Claimant's impairment is "mild with decreased FEV_1, chronic bronchitis and coal workers' pneumoconiosis 1/0," and that each of the diagnoses he made fully contributed to Claimant's impairment.

By deposition testimony taken on December 19, 2005, Dr. Baker elaborated on several statements made in his medical opinion. Notably, Dr. Baker stated that the wheezing he heard while examining Claimant was consistent with COPD. (*CX* 1 at 4:8-16.) Moreover, Dr. Baker explained that the fact that Claimant's blood-gas study test results were normal did not mean that Claimant does not have a pulmonary disease because there "is not a good correlation between pulmonary disease and arterial blood gases." (CX 1 at 7:6-12.) Additionally, although Dr. Baker stated that the abnormalities he saw on Claimant's x-ray were consistent with pneumoconiosis, Dr. Baker also stated that there are other conditions, which could have caused the abnormalities. (CX 1 at 5:14-18.) On the other hand, Dr. Baker stated that the only way to find out if the abnormalities were caused by another condition would be to perform a lung biopsy. (CX 1 at 5:14-18; 12:9-12.) With regard to the "B" opacity that Dr. Baker noted on

[23] The test data is contained in Director's Exhibit 14.

Claimant's x-ray, Dr. Baker acknowledged that there are over a hundred different possibilities of what the opacity might be. (CX 1 at 12:9-16.)

With regard to Dr. Baker's diagnosis that Claimant's impairment is mild, Dr. Baker explained in his deposition that this diagnosis merely meant that Claimant's pulmonary study values were between 60% and 80% of predicted. (CX 1 at 6:9-18.) Dr. Baker further explained that an impairment classified as "mild" does not "mean that it is a mild problem in the patient that has it[,]" and that "it is still a major problem for the patient in terms of their breathing capacity." (CX 6:9-18.) Furthermore, Dr. Baker stated that based on Claimant's breathing tests, he did not believe that Claimant would be able to perform a position, which constituted hard labor (lifting 25 lbs. often and 50 lbs. and 100 lbs. occasionally) on a regular basis. (CX 1 at 6:22-7:5, 9:22-25.) Dr. Baker stated that, when he considered Claimant's work history, he felt that Claimant was totally disabled for his occupation as a miner. (CX 1 at 9:5-8.) Moreover, Dr. Baker stated that he felt coal dust exposure was a factor in causing Claimant's disability because coal dust exposure is a cause of obstructive airways disease, which Claimant suffers from, and Claimant was exposed to coal dust for more years than he smoked. (CX 1 at 9:9-14.)

More specifically, Dr. Baker stated that both Claimant's COPD and FEV_1 value of 62% of predicted were due to Claimant's cigarette smoking and coal dust exposure. Dr. Baker stated that both cigarette smoking and coal dust exposure can cause COPD. (CX 1 at 7:21-26.) With regard to Claimant's decreased FEV_1 value, Dr. Baker noted that studies have suggested that miners experience a ".5 to 1 cm" decrease on average in their FEV_1 values while smokers experience, on average, a "1 cm" decrease in their FEV_1 values. Dr. Baker stated that one could then compare the length of dust exposure to smoking exposure and that when he considered Claimant's eleven to twelve pack year smoking history and Claimant's seventeen years of coal mine employment, he concluded that at least 50%, if not more, of Claimant's problems were due to his past coal mine employment.[24] (CX 1 at 8:6-25.) Moreover, Dr. Baker noted that some researchers have found that there is an additive or synergistic effect between coal dust exposure and cigarette smoking, so that an individual's condition will be worse if he is exposed to both than if he had only been a smoker or coal miner. (CX 1 at 8:6-25.) Dr. Baker stated that he did not administer a bronchodilator in his breathing studies and did not determine Claimant's carboxy level. (CX 1 at 13:13-14:17.)

At his deposition, Dr. Baker also stated that he knew Claimant has a history of tuberculosis, which required resection of part of Claimant's lung. (CX 1 at 10:9-12.) Yet, with regard to the effect resection of Claimant's lung has had on Claimant's respiratory health, Dr Baker stated that, while he did not know how much of Claimant's lung was removed, resection of Claimant's lung, if it had a significant effect on Claimant's respiratory health, would have caused a restrictive defect. (CX 1 at 10:13-19.) Dr. Baker noted that Claimant suffers from an obstructive defect. (CX 1 at 10:13-19.) On the other hand, Dr. Baker stated at his deposition that he was unaware of Claimant's history of histoplasmosis. (CX 1 at 10:20-23.) With regard to histoplasmosis in general, Dr. Baker stated that the residual effect of having the condition is either terrible scarring or no residual effect. (CX 1 at 11:3-7.) Dr. Baker stated that in reading Claimant's x-ray, except for the "B" opacity, he diagnosed early stage pneumoconiosis. (CX 1 at

[24] Dr. Baker calculated Claimant's eleven to twelve pack year history based on Claimant's history of smoking one half a pack per day for twenty-one to twenty-two years.

11:8-11.) Dr. Baker noted that "[u]sually histoplasmosis always gets severe calcifications and [Claimant] didn't have that on his x-ray." (CX 1 at 11:8-11.) Also with regard to Dr. Baker's reading of Claimant's x-ray, Dr. Baker, who noted irregular shaped opacities on his x-ray report, stated that, although rounded opacities are more common, irregular shaped opacities occur as well. (CX 1 at 11:12-22.) In his deposition testimony, Dr. Baker pointed out how the "very first x-ray on the sample test … for the black lung examination for the "B" reader test[] shows irregular opacities" and says that while the opacities are irregularly shaped, they may still be due to coal dust. (CX 1 at 11:17-22.)

Medical Opinion (Report and Deposition Testimony) by Dr. Abdul Dahhan (DX 17)

Dr. Dahhan, who is a B-reader and board-certified in internal medicine with a subspecialty in pulmonary disease, examined Claimant on April 24, 2003. His findings are summarized in a medical report dated May 1, 2003. In this report, Dr. Dahhan noted that Claimant worked in the mining industry performing underground loading and rock dusting for seventeen years. Dr. Dahhan also noted that Claimant smoked three-fourths of a pack of cigarettes per day beginning at age twenty and quit smoking in 1985 (approximately twenty-two years).

Dr. Dahhan noted in his report that Claimant had a history of daily cough with production of clear sputum and frequent wheeze. Dr. Dahhan also noted Claimant's medications and that Claimant complained of "dyspnea on exertion such as a flight of stairs," and that Claimant had a history of hypertension, which was being treated with medication, and that Claimant suffered occasional chest pain, although Claimant was not on Nitroglycerin.

In his medical report, Dr. Dahhan also summarized his review of Claimant's systems and noted that claimant had had a left lower lobectomy as treatment for tuberculosis. Dr. Dahhan also noted that he observed no abnormalities or problems when he examined Claimant, except that upon examining Claimant's chest, Dr. Dahhan noted "a surgical scar over the left chest with scattered expiratory wheeze."

In his medical report, Dr. Dahhan also reviewed the medical tests he had performed on Claimant: (1) EKG showed regular sinus rhythm with normal tracings, (2) arterial blood-gas test performed while Claimant was at rest showed normal values; (3) pulmonary function tests were compatible with a mild obstructive ventilatory abnormality; (4) chest x-ray revealed opacities in Claimant's upper lung zones consistent with simple coal workers' pneumoconiosis, although no large opacities were seen, and a pacemaker in Claimant's left chest cavity, a coalescence of lesions in the right upper zones with bullae formation, and post op changes in the left chest.

Based on the foregoing, Dr. Dahhan stated that he could make the following conclusions within a reasonable degree of medical certainty: (1) Claimant has radiological findings compatible with simple coal workers' pneumoconiosis, although based on Claimant's history, these findings could be due to his tuberculosis infection; (2) Claimant has a mild ventilatory impairment caused by Claimant's previous left lower lobectomy and previous smoking habit, although there is no evidence of total or permanent pulmonary disability; (3) that from a respiratory standpoint, Claimant retained the physiological capacity to continue his previous coal

mining work or a job of comparable physical demand; and (4) Claimant has tuberculosis post resection of the left lower lobe and a permanent pacemaker, which are both conditions of the general public at large and are in no way caused by or aggravated by the inhalation of coal dust or coal workers' pneumoconiosis.

In a deposition taken on August 24, 2004, Dr. Dahhan discussed his medical report and opinions regarding Claimant. (EX 3.) With regard to Claimant's left lower lung lobectomy as treatment for tuberculosis, Dr. Dahhan opined that this surgery resulted in approximately a 20% to 25% reduction of Claimant's overall lung capacity. (EX 3 at 7:25-8:15.) Dr. Dahhan explained that the left lung has two lobes and the right lung has three lobes. (EX 3 at 7:11-13.)

With regard to his determination that Claimant does not have complicated pneumoconiosis, Dr. Dahhan stated that Claimant's x-ray revealed no large opacities, which Dr. Dahhan said must be present in order to diagnose complicated coal workers' pneumoconiosis by x-ray. (EX 3 at 11:10-15; 16:11-23; 20:14-17.) Moreover, Dr. Dahhan stated that he did not find any other masses of 1 centimeter or larger in Claimant's lungs that he thought were related to any other condition or disease. (EX 3 at 16:20-23.) On the other hand, Dr. Dahhan did state that seventeen years of coal mine employment is a sufficient time to contract complicated pneumoconiosis. (EX 3 at 17:17-19.)

With regard to Claimant's history of histoplasmosis, Dr. Dahhan testified that Claimant did not tell him of his past history of the disease and that he did not detect the disease during his examination of Claimant. (EX 3 at 11:16-24.) On the other hand, Dr. Dahhan stated that it was possible that Claimant confused tuberculosis and histoplasmosis in his mind and that what Claimant told him was treatment for tuberculosis was really treatment for histoplasmosis. (EX 3 at 11:20-24.) Dr. Dahhan stated that histoplasmosis leaves scarring on the lungs that can mimic the presence of coal workers' pneumoconiosis and that these scars are difficult to distinguish from coal workers' pneumoconiosis opacities. (EX 3 at 12:10-15.)

With regard to Claimant's history of tuberculosis, Dr. Dahhan stated that he did not know if Claimant's tuberculosis was currently active. (EX 3 at 18:3-5.) Dr. Dahhan stated that in order to know if Claimant's tuberculosis was currently active, he would have had to perform a sputum exam, which he did not do when he examined Claimant. (EX 3 at 18:6-12.) In this case, at the time of Dr. Dahhan's deposition, he had not reviewed Claimant's biopsy or bronchoscopy treatment records. (EX 3 at 20:3-7.) Had he seen a bronchoscopy report, Dr. Dahhan stated that he would have expected to see excessive mucous and some scarring from Claimant's old tuberculosis and/or histoplasmosis. (EX 3 at 18:13-24.) Moreover, although Dr. Dahhan stated that excessive mucous production could be caused by enlarged goblet cells, which become enlarged when they are irritated, Dr. Dahhan stated that coal dust does not irritate goblet cells. (EX 3 at 18:25-19:7.) Dr. Dahhan also stated that, in a biopsy, he would expect to find some evidence of either tuberculosis or active tuberculosis in the form of granuloma, which represent tuberculosis. (EX 3 at 19:16-20-2.)

Dr. Dahhan also stated that the mild ventilatory impairment he opined Claimant has is due to Claimant's left lower lung lobectomy and smoking history. (EX 3 at 12:16-13.) Dr. Dahhan stated that he did not find any evidence that Claimant's reduced ventilatory capacity was a result of coal worker's pneumoconiosis. (EX 3 at 12:16-13.) Dr. Dahhan stated that the

Department of Labor standardized tables are not based on an individual who has lungs that have been compromised by surgical intervention such as Claimant. (EX 3 at 12:24-13:15.) Dr. Dahhan also stated that he believed that Claimant's FEV_1 value qualified under the Department of Labor standardized tables, but that the reduction in Claimant's FEV_1 and FVC values was primarily due to Claimant's lung resection. (EX 3 at 13:16-14:7; 24:5-9.) Dr. Dahhan estimated that the resection caused roughly a 20% reduction in Claimant's FEV_1 value. (EX 3 at 24:10-13.) Dr. Dahhan stated that, had Claimant not had a lung lobectomy, he estimated that Claimant's FEV_1 would be 81% of predicted. (EX 3 at 24:22-25:5.)

Dr. Dahhan also stated in his deposition that his opinion that Claimant retains the physiological capacity to continue his previous coal mining employment was based on Claimants' arterial blood-gas, FVC, FEV_1, and diffusion capacity values. (EX 3 at 14:8-13.) Moreover, Dr. Dahhan stated that Claimant's heart condition had nothing to do with the inhalation of coal dust because Claimant's "EKG showed no evidence of cor pulmonale, which can be one of the cardiac manifestations of coal dust induced lung disease." (EX 3 at 15:12-25.) On the other hand, Dr. Dahhan did opine that Claimant has coal workers' pneumoconiosis, which was caused by coal dust, and when told to assume that Claimant had to perform heavy labor as part of his coal mine employment, Dr. Dahhan acknowledged that, based on Claimant's FEV_1, there was a question as to whether Claimant could perform that work.[25] (EX 3 at 20:18-21:13.)

With regard to Claimant's smoking history and respiratory condition, Dr. Dahhan stated that he thought Claimant's fifteen year pack smoking history could have caused Claimant to develop bronchitis because such a history is sufficient to cause such a condition in a susceptible host.[26] (EX 3 at 16:1-10.) Dr. Dahhan stated that Claimant was being treated with "multiple bronchodilator therapy indicating that his physician thought that he does have airway obstruction amenable to such measures." (EX 3 at 16:1-10.) On the other hand, Dr. Dahhan stated that he did not diagnose Claimant with chronic bronchitis because Claimant has a "history of tuberculosis which by definition can cause cough and sputum production." (EX 3 at 17:20-25.) Accordingly, although claimant had a history of cough and sputum production, Dr. Dahhan stated that the tuberculosis "negates the requirement for the definition of chronic bronchitis." (EX 3 at 17:20-18:2.)

On the other hand, Dr. Dahhan also stated at his deposition that the exact mechanism for how coal dust exposure causes chronic obstructive pulmonary disease is not known. (EX 3 at 19:8-10.) Specifically, Dr. Dahhan stated that it "can cause bronchitis with simply the symptoms of cough and sputum production due to the overwhelming of the respiratory defenses by the dust so the individual has to expectorate it and that's the mechanism for the cough and unusual amount of sputum that is brought up." (EX 3 at 19:8-15.) Dr. Dahhan acknowledged that physicians rely on an epidemiological function to evaluate coal dust exposure induced obstructive disease. (EX 3 at 23:9-15.) Dr. Dahhan stated that based on epidemiological

[25] Dr. Dahhan was asked to assume that as a miner, Claimant lifted a hundred pounds occasionally, fifty pounds frequently, and had to shovel up to twenty pounds on a continuous basis. (EX 3 at 21:7-13.)

[26] Based on Claimant's smoking history of three-fourths of a pack per day from age twenty until Claimant quit in 1985, Dr. Dahhan calculated Claimant's pack year history to be approximately 15 pack years. (EX 3 at 7:17-21.)

function, he estimated that approximately one hundred cubic centimeters of Claimant's obstructive airway disease was due to coal dust exposure. (EX 3 at 23:9-19.) On the other hand, Dr. Dahhan also acknowledged that not all smokers suffer a deficit in their FEV_1 values and that it was not possible to know whether Claimant's FEV_1 deficit was caused by smoking. (EX 3 at 26:9-21.) Accordingly, Dr. Dahhan further acknowledged that the epidemiology predictions regarding the percentage of the FEV_1 deficit in an individual due to smoking could be smaller and that the percentage due to coal dust could be larger that predicted. (EX 3 at 26:9-27:7.)

Medical Opinion (Report) by Dr. Gregory Fino (DX 18)

In a medical report dated July 15, 2003, Dr. Fino, who is a B-reader and board-certified in internal medicine with a subspecialty in pulmonary disease, summarized his findings regarding his examination of Claimant, which occurred on June 19, 2003. In his report, Dr. Fino noted Claimant's age and medications, as well as Claimant's family history. Dr. Fino also noted that Claimant smoked less than a pack per day for twenty-two years and that Claimant worked as an underground miner for twenty years. Moreover, Dr. Fino noted that Claimant's job involved heavy labor.

Dr. Fino also noted in his medical report Claimant's symptoms, which included: daily cough and mucous production, complaint of chest pain, limitation of activities due to breathing, and shortness of breath, which Claimant first noted in 2000. Regarding Claimant's shortness of breath, Dr. Fino noted that it does not interfere with Claimant's usual activities and that Claimant does not become dyspneic when walking at his own pace on level ground or ascending one flight of steps. On the other hand, Dr. Fino did note that dyspnea does occur when Claimant walks up hills or grades, lifts and carries items, performs manual labor, and walks briskly on level ground.

Regarding Claimant's past medical history, Dr. Fino noted the following: (1) tuberculosis (hospitalized for 5 months), 1963; (2) left lower lobectomy, 1963; (3) pacemaker, 1986; (4) emphysema; (5) bronchitis; (6) frequent colds; (7) frequent headaches; and (8) heart problems. Dr. Fino noted that Claimant had no history of pneumonia, asthma, bronchiectasis, or fractured ribs.

Dr. Fino also reviewed Claimant's systems and noted no problems, including no diabetes, and physically examined Claimant, which revealed no abnormalities or problems other than a decrease in breath sounds bilaterally when Dr. Fino examined Claimant's lungs. In another section of his medical report, Dr. Fino summarized the chest x-ray results, pulmonary function test results and arterial blood-gas test results. Regarding Claimant's chest x-ray, Dr. Fino noted that is was a very abnormal chest film. Notably, there were changes in both upper lobes that Dr. Fino stated suggested chronic nodular fibrosis due to old granulomatous disease. Dr. Fino also noted that the x-ray revealed a mass-like abnormality in the right lung and one in the lower portion of the left lung, and that these changes were consistent with Claimant's history of tuberculosis in 1963. Lastly, Dr. Fino noted that Claimant had volume loss of the left lung consistent with his history of a left lower lobectomy, that there was a pacemaker present, and that Dr. Fino classified Claimant's x-ray as 0/0 for opacities consistent with pneumoconiosis. With regard to Claimant's blood-gas test results, Dr. Fino noted that they were normal. On the other hand, with regard to Claimant's pulmonary function tests, Dr. Fino noted that the tests revealed

that Claimant had moderate obstruction, a combined obstructive and restrictive abnormality in lung volumes, and a reduced diffusing capacity.

Based on the foregoing, and most heavily on Claimant's x-ray and history of treatment for tuberculosis, Dr. Fino diagnosed Claimant as suffering from "a combined obstructive and restrictive ventilatory abnormality" caused by significant lung scarring due to old tuberculosis. Dr. Fino opined that the restrictive abnormality was caused by the removal of a portion of Claimant's left lung and the significant scarring resulting from Claimant's tuberculosis. Dr. Fino stated that Claimant's obstructive abnormality was also "consistent with tuberculosis." Dr. Fino noted that tuberculosis, such as that suffered by Claimant, "can cause bronchiectasis which could result in an obstructive abnormality. Dr. Fino also noted that Claimant was a former smoker and had coal mine dust exposure, although he did not believe that either of these exposures were clinically significant and that they did not contribute significantly to Claimant's impairment. Overall, Dr. Fino found that there was insufficient objective medical evidence to justify a diagnosis of coal workers' pneumoconiosis, although he did find that Claimant suffers from a disabling respiratory impairment that causes Claimant to be disabled from returning to his last mining job or a job requiring similar effort. On the other hand, Dr. Fino stated that this disability is not due to Claimant's coal mine dust exposure and that even if he "were to assume that [Claimant had] coal worker's pneumoconiosis, it [did] not contribute[] to his disability."

F. Hospitalization records and treatment notes (DX 16, CX 1)

Claimant's hospitalization records and treatment notes contain a health problem list, medication records, chest x-ray reports, a CT scan report, pulmonary function study and blood-gas study test results, and physician's notes documenting Claimant's treatment for a number of ailments including sinusitis, upper respiratory infection/bronchitis, chronic obstructive pulmonary disease ("COPD"), a heart condition, dyspnea, and pneumoconiosis. Claimant's records also note his past medical history, which includes histoplasmosis, hyperlipidemia, mitral valve prolapse, pacemaker, tuberculosis, and left upper lung lobe resection.

The CT scan in Claimant's records is dated April 25, 2003 and states that there is a 3.9 by 3.1 cm mass like density in Claimant's right upper lung lobe and a 2.4 by 2 cm nodular density in Claimant's left upper lung lobe. (DX 16 at 23.) The report also states that there are "associated peripheral infiltrates in the right upper lobe and the left upper lobe[,]" and "[b]ilateral upper lobe and left lower lobe bolus changes." (DX 16 at 23.)

III. Evidence from Claimant's Prior Federal Black Lung Claims

Summarized below is the evidence that was admitted and considered in Claimant's two prior federal claims.[27] This evidence is part of the record for the current claim pursuant to 20 C.F.R. § 725.309(d)(1).[28]

[27] Claimant's prior claims contain testimony by the Claimant given by deposition and at the prior hearing. The Presiding Judge has reviewed this testimony and finds that it is consistent with the information provided in conjunction with Claimant's current claim. This information has already been summarized in this Decision. Accordingly, Claimant's testimony from his prior claims is not summarized herein. Moreover, the Presiding Judge notes that slight differences and additional information detailed in Claimant's testimony in his prior claims regarding his employment and smoking history are not significant and therefore do not affect the Presiding Judges findings as

A. Chest x-rays

The following chest x-ray reports are in the record:

Exhibit # (Exhibit # in Prior Claim)	*Name of Reader*	*Radiological Qualification*	*Date of Study*	*Date of Reading*	*Film Quality*	*Reading*	*Large Opacities*
Chest x-rays Submitted as Part of Claimant's April 1, 1987 Claim							
DX 1 (DX 59 at 84, 240)	Dr. William Anderson	Not noted	7/24/86	7/24/86		Category 1	
DX 1 (DX 59 at 239, 245)	Dr. T.R. Marshall	BCR, B	7/24/86	9/26/86	1	1/0, p/p, All lung zones	0
DX 1 (DX 59 at 237, 244)	Dr. Maurice Bassali	BCR, B	7/24/86	10/6/86	1	1/0, q/t, All lung zones	
DX 1 (DX 59 at 233, 243, 246)	Dr. Cordell Williams	None	7/24/86	2/10/87	2	1/0 , q/p, R(M, L)/L(M, L)	
DX 1 (DX 59 at 10, 190)	Dr. Bruce Broudy	B	7/24/86	6/15/87	1	No abnormalities	
DX 1 (DX 59 at 12, 192)	Dr. John Harrison	B	7/24/86	6/22/1987	Good	0/1, p/p	
DX 1 (DX 59 at 14, 194)	Dr. Alex Poulos	BCR, B	7/24/86	7/10/87	Not noted	No evidence of pneumo	
DX 1 (DX 59 at 24, 196)	Dr. Dennis Halbert	BCR, B	7/24/86	7/31/87	Satisfactory	No evidence of pneumo	
DX 1 (DX 59 at 238)	Dr. Lowell Martin	Not noted	9/26/86	9/26/86	Good	1/1, q, silicosis	
DX 1 (DX 59 at 232)	Dr. Peeter Jakobson	Not noted	9/26/86	9/30/86	Not noted	1/0, t/t, R(M)/L(M), Silicosis	
DX 1 (DX 59 at 33, 58, 235)	Dr. Ballard Wright	None	10/11/86	10/11/86	Excellent	1/0, R(M, L)/L(M, L)	
DX 1 (DX 59 at 20, 184)	Dr. Benjamin Felson	BCR, C, B	10/11/86	6/24/87	3	Negative	
DX 1 (DX 59 at 28, 186)	Dr. Harold Spitz	BCR, B	10/11/86	7/15/87	1	No abnormalities	
DX 1 (DX 59 at 52, 188)	Dr. Jerome Wiot	BCR, B	10/11/86	8/19/87	2	No abnormalities	
DX 1 (DX 59 at 116, 145, 234, 258)	Dr. Robert Penman	None	10/25/86	10/25/86	Good	1/1, p	
DX 1 (DX 59 at 10, 166)	Dr. Bruce Broudy	B	2/16/87	2/16/87	1	No abnormalities	
DX 1 (DX 59 at 246)	Dr. Cordell Williams	None	4/21/87	4/21/87	1	0/1, p/s, R(M, L)/L(M, L)	0
DX 1 (DX 59 at 14, 195)	Dr. Alex Poulos	BCR, B	5/21/87	5/21/87	1	No abnormalities	
DX 1 (DX 59 at 16, 173)	Dr. Emory Lane	B	6/3/87		2	0/0	

set forth above.

[28] Reference in this section to an exhibit's prior claim exhibit number refers to the director exhibit/page number assigned to the evidence in Claimant's second claim filed on July 7, 1994.

DX 1 at (DX 59 at 12, 178)	Dr. John Harrison	B	6/23/87	6/23/87	Good	0/0	
Chest x-rays Submitted as Part of Claimant's July 7, 1994 Claim							
DX 1 at 913 (DX 25)	Dr. Glen Baker	B	8/25/94	8/25/94	1	2/1, r/q	A
DX 1 at 915 (DX 22)	Dr. E. Nicholas Sargent	BCR, B	8/25/94	9/14/94	3	1/0, r/r, R(U)/L(U)	0
DX 1 at 912, 916 (DX 23)	Dr. Peter Barrett	BCR, B	8/25/94	9/16/94	2	1/2, q/t, All lung zones	A
DX 1 at 393 (E2-3)	Dr. Ben Branscomb	B	8/25/94	7/17/96	2	1/1, q/t, R(U)	0
DX 1 at 900, 921 (DX 59 at 10, 19, 27)	Dr. Bruce Broudy	B	11/1/94	11/2/94	1	2/2, r/q, R(U, M)/L(M)	A
DX 1 at 911 (DX 24)	Dr. E. Nicholas Sargent	BCR, B	11/1/94	1/3/95	1	0/1, q/q, All lung zones	0
DX 1 at 393 (E2-2,3)	Dr. Ben Branscomb	B	11/1/94	7/17/96	1	1/1, q/t, R(U)	0
DX 1 at 808, 898 (DX 50, 28)	Dr. Jerome Wiot	BCR, B	11/1/94	12/3/94	1	1/1, q/r, R(U)/L(U, M)	B
DX 1 at 797 (DX 50)	Dr. Ballard Wright	Not noted	5/13/95	5/13/95	1	1/2, q/r, All lung zones	0
DX 1 at 803, 805 (DX 50)	Dr. Ballard Wright	Not noted	6/10/95	6/10/95	1	1/2, q/q, All lung zones	0

B. Biopsy Evidence[29]

Biopsy Report by Dr. C.B. Bella (DX 1 at 966 (prior claim exhibit # DX 15))

In this instance, the biopsy specimens were collected by Dr. Rene Mandanas by bronchoscopy on February 24, 1988. Upon examination, Dr. Mandanas noted that the right upper, middle, and lower lobe bronchial openings were all patent and normal and that no lesions were seen. Dr. Mandanas also noted that the left lower lobe bronchi and left main bronchi were also normal, but that the left upper lobe bronchial mucosa was slightly erythematous. He further noted that the lingular bronchial opening was patent and that the left upper lobe, anterior and apical posterior segments, were "coming off at a steep angle such that there was a bronchial mucosa covering it from direct view." On the other hand, when passing the scope around the bronchial mucosa, Dr. Mandanas noted that the opening itself was patent. Dr. Mandanas also noted that no masses were seen and that there "was some bronchial mucosa erythema and some bronchial mucosa edema, as with acute bronchitis." Dr. Mandanas also noted that not much secretion was suctioned out.

Dr. Bella's pathology report, dated February 25, 1988, states both gross and microscopic findings. Dr. Bella, whose qualifications are unknown, noted that the tissue specimens, taken from Claimant's left upper lung were pink, tan, and gray in color. Washings and sputum cell block were also analyzed. Microscopic examination revealed lung parenchyma with areas

[29] The two bronchoscopy and biopsy procedures by Dr. Bella summarized in this section were not performed for the specific purpose of evaluating whether Claimant had coal workers' pneumoconiosis.

showing fibrosis; mild edema; prolapsed alveoli; collections of macrophages and columnar epithelial cells, some of which showed anthracotic pigments; sectors with anthracotic pigments; sectors where nodular configuration of the areas where fibrosis was present; marked anthracotic figures and polarizing silicone particles; and inflammatory cells. Based on the foregoing, Dr. Bella diagnosed mild fibrosis and focal edema; anthracosilicosis; a few inflammatory cells; pulmonary histiocytes and anthracotic pigments; and no malignancy.

Biopsy Report by Dr. C.B. Bella (DX 1 at 966 (prior claim exhibit # DX 15))

By bronchoscopy performed by Dr. Rene Mandanas on June 22, 1988, bronchial washings and brushings were obtained from the upper left lobe bronchi and right lung area. Tissue samples were also obtained from the upper left lobe bronchi and right lower lobe superior basal and basal segments. Dr. Mandanas noted that the right upper, middle, and lower lobe bronchi all appeared normal, although there was very slight erythema on the right side. Dr. Mandanas also noted that there was slightly more erythematous in the upper left lobe bronchi than the rest of the lung and that there "was a steep angle of take-off of the upper lobe segments such that there was bronchial mucosa covering it from direct view." Yet, Dr. Mandanas noted that the bronchial opening itself was patent, no masses were seen, and the left lower lobe bronchi were normal.

In a pathology report dated June 23, 1988, Dr. Bella made both gross and microscopic findings. On gross examination, Dr. Bella noted that the tissue specimens ranged in color from pale-tan to gray-tan. Washings and sputum cell block were also analyzed. Microscopic examination revealed no malignancy; groups of columnar epithelial cells, a few showing mild nuclear hyperchromaticity; inflammatory cells, lymphocytes, polymorphonuclear segmenters, and a few histiocytes; and a few mild atypical epithelial cells. Based on the biopsies from the right lung, Dr. Bella diagnosed interstitial fibrosis and mild chronic inflammation. Based on the biopsies from the left lung, Dr. Bella diagnosed chronic inflammation and fibrosis.

Biopsy Report by Dr. Edmond Crouch (DX 1 at 919 (prior claim exhibit # DX 20))[30]

On April 19, 1995, Dr. Crouch, whose qualifications are unknown, examined the surgical pathology report and specimens contained in six glass slides which were originally examined by Dr. Bella on June 22, 1988. Upon microscopic examination, Dr. Crouch noted that the left upper lobe biopsy showed bronchial mucosa with mild chronic inflammation and no associated alveolar tissue. He further noted that the right lobe biopsy showed bronchial mucosa and associated gas exchange tissue and that the "latter areas showed very mild nonspecific interstitial fibrosis and chronic inflammation as well as increased numbers of airspace macrophages." Dr. Crouch also found that the "parenchyma and intra-alveolar macrophages contain[ed] moderate amounts of irregular to angulated black particles consistent with coal dust" and that black core ferruginous bodies were also identified. Dr. Crouch noted that polarization microscopy only revealed rare, short needle-like birefringent bodies consistent with silicates and that "biopsy

[30] This exhibit contains two pages, yet after careful review, the Presiding Judge finds that the second page was mistakenly included in the file and is not in fact part of Dr. Crouch's pulmonary pathology consultation report for Claimant. Accordingly, DX 1 page 919 (designated as page 2 of DX 20 in Claimant's prior claim) is excluded from the record.

show[ed] no coal dust macules, micronodules, nodules or silicotic nodules. Lastly, Dr. Crouch noted that the cell blocks showed bronchial epithelial and inflammatory cells.

Based on the foregoing, Dr. Crouch found that the right lobe, transbronchial biopsies revealed coal dust deposition and nonspecific mild interstitial fibrosis and chronic inflammation. Yet, Dr. Crouch noted that only one of the slides he reviewed included alveolar tissue and that while this slide showed definite evidence of coal dust, Dr. Crouch did not identify any lesions associated with coal workers' pneumoconiosis. Dr. Crouch therefore stated that, because the sampling of lung tissue he reviewed was very limited, he could not give a definitive assessment regarding whether Claimant had pneumoconiosis or what possible contribution coal dust exposure may have had to any pulmonary disability suffered by Claimant.

C. Pulmonary Function Studies

The following pulmonary function studies are in the record:

Exhibit # (Exhibit # in Prior Claim)	*Physician*	*Date of Test*	*age/height (in) /effort*	*3 Tracings*	*FEV1*	*FVC/ MVV*	*FEV1/ FVC (%)*	*Qualifies?*
Pulmonary Function Studies Submitted as Part of Claimant's April 1, 1987 Claim								
DX 1 (DX 59 at 235)	Dr. Ballard Wright	10/11/86	43 / 68.5 / Not noted	No	3.5	4.5 / 131	77.78%	No
DX 1 (DX 59 at 116, 145, 147)	Dr. Robert Penman	10/25/86	43 / 68 / Not noted	Yes	3.06	3.9 / --	78.46%	No
DX 1 (DX 59 at 165)	Dr. Bruce Broudy	2/16/87	43 / 70 / Good	No	3.09	4.1 / 114	75.37%	No
DX 1 (DX 59 at 259)	Dr. Cordell Williams	4/21/87	43 / 69 / Good	Yes	3.64	4.65 / 101	78.28%	No
DX 1 (DX 59 at 3, 177)	Dr. Emory Lane	6/3/87	44 / Not noted / Not noted	Yes	3.25	4.32 / 126	75.23%	No
DX 1 (DX 59 at 182)	Dr. John Harrison	6/23/87	44 / 70 / Not noted	Yes	3.5	4.5 / --	77.78%	No
Pulmonary Function Studies Submitted as Part of Claimant's July 7, 1994 Claim								
DX 1 at 1006 (DX 12)	Dr. Glen Baker	8/25/94	51 / 68.75 / Good	Yes	2.48	4.21 / 104	58.91%	No
DX 1 at 1001 (DX 13)	Dr. Bruce Broudy	11/1/94	51 / 69.25 / Fair	Yes	2.75	4.28 / 99	64.25%	No
DX 1 at 795 (DX 50)	Dr. Ballard Wright	5/13/95	52 / 69 / Not noted	Yes	2.42	4.11 / --	58.88%	No
DX 1 at 804 (DX 50)	Dr. Ballard Wright	6/10/95	52 / 69 / Not noted	Yes	2.28	3.88 / --	58.76%	No

D. Arterial Blood-Gas Studies

The following blood gas studies are in the record:

Exhibit #	*Physician*	*Date of Test*	*Altitude (feet)*	*Resting Exercise*	*PCO2*	*PO2*	*Qualifies?*
Arterial Blood-Gas Studies Submitted as Part of Claimant's April 1, 1987 Claim							

DX 1 (DX 59 at 84, 240)	Dr. William Anderson	7/24/86	Not noted	R	39	84	No
DX 1 (DX 59 at 236)	Dr. Ballard Wright	10/11/86	Not noted	R	38.3	96.3	No
DX 1 (DX 59 at 146)	Dr. Robert Penman	10/25/86	Not noted	Not noted	39.0	76.1	No
DX 1 (DX 59 at 164)	Dr. Bruce Broudy	2/16/87	0-2999	R	34.7	92.2	No
DX 1 (DX 59 at)	Dr. Cordell Williams	4/21/87	0-2999	R	40.3	86.1	No
DX 1 (DX 59 at 177)	Dr. Emory Lane	6/3/87	Not noted	R	37.3	84.5	No
DX 1 (DX 59 at 181)	Dr. John Harrison	6/23/87	Not noted	R	38	84	No
Arterial Blood-Gas Studies Submitted as Part of Claimant's July 7, 1994 Claim							
DX 1 at 918 (DX 21)	Dr. Glen Baker	8/25/94	0-2999	R	34.1	102.2	No
DX 1 at 1001 (DX 13)	Dr. Bruce Broudy	11/1/94	Not noted	R	34.0	99.1	No
DX 1 at 806 (DX 50)	Dr. Ballard Wright	6/10/95	Not noted	R	37.0	94.8	No

E. Medical Opinions

Dr. William Anderson (DX 1 at 452 (prior claim exhibit # DX 59 at 82, 200, 240))

Dr. Anderson, who is board-certified in internal medicine and has a subspecialty in pulmonary disease, examined Claimant on July 24, 1986. Dr. Anderson was deposed on April 7, 1987. In that deposition, Dr. Anderson described his examination of Claimant and discussed his opinions regarding Claimant's pulmonary health, which are summarized in a report dated September 8, 1986. As part of his examination of Claimant, Dr. Anderson considered Claimant's employment, medical, and smoking histories and performed a physical examination, EKG, pulmonary function study, arterial blood-gas study, and chest x-ray.

Based on the foregoing, Dr. Anderson diagnosed Claimant with category I pneumoconiosis, although he found Claimant's blood-gas study and pulmonary function study test results to be normal. Dr. Anderson stated that category I pneumoconiosis does not cause any symptoms and that the blood-gas study and pulmonary function study test results indicate that Claimant's lungs were functioning in a normal manner and that Claimant's shortness of breath could not be due to a pulmonary cause. Dr. Anderson stated that Claimant's stage I pneumoconiosis, in and of itself, would not affect Claimant's pulmonary capability to perform hard manual labor outside of the mines. Dr. Anderson also attributed Claimant's shortness of breath and his being awakened at night by shortness of breath that was relieved by getting up to his heart disease, which Dr. Anderson stated was not related to his coal mine employment. On the other hand, Dr. Anderson stated that he did not believe that any of Claimant's symptoms were due to the removal of a portion of Claimant's left lung and also stated that Claimant's smoking history attributed to Claimant's symptoms only to the extent that it may have hastened the development of Claimant's heart disease for which he had to have a pacemaker implanted. On the other hand, Dr. Anderson stated that there is no treatment for pneumoconiosis and that it may be progressive.

In a supplemental report dated April 25, 1989, Dr. Anderson opined that, based on his July 24, 1986 examination, Claimant has an occupational lung disease which was caused by his coal mine employment, but that Claimant did not suffer from any pulmonary impairment. Dr.

Anderson therefore further opined that Claimant had the respiratory physiological capacity to perform the work of a coal miner or comparable work in a dust-free environment.

Dr. Lowell Martin (DX 1 at 452 (prior claim exhibit # DX 59 at 238))

Dr. Martin, whose qualifications are unknown, examined Claimant on September 26, 1986. For that examination Dr. Martin physically examined Claimant and took Claimant's chest x-ray. Dr. Martin noted that Claimant had worked for seventeen years as an underground coal miner and that Claimant had a pacemaker, clubbing and blue nails. Dr. Martin also noted that physical examination of Claimant disclosed that he suffered from shortness of breath. Based on the foregoing, Dr. Lowell diagnosed Claimant as having pneumoconiosis 1/1, type q silicosis and opined that Claimant should not return to underground coal mining due to his silicosis.

Dr. Ballard Wright (DX 1 at 452 (prior claim exhibit # DX 59 at 9, 33, 58, 235))

Dr. Wright, who is board-certified in anesthesiology, examined Claimant on October 11, 1986. In a deposition taken on May 9, 1987, Dr. Wright discussed his findings regarding Claimant, which were summarized in a report dated October 11, 1986. In conducting his examination, Dr. Wright noted Claimant's employment, medical, and smoking histories and performed a physical examination, EKG, chest x-rays, pulmonary function studies, and blood-gas studies.

Based on this examination, Dr. Wright stated that Claimant suffered from an obstructive airflow defect or small airways disease and that Claimant's work as a miner was a contributing factor to this condition. Moreover, Dr. Wright stated that it was impossible to determine what portion of Claimant's airflow disease was attributable to cigarette smoking and what portion was due to dust exposure. Dr. Wright stated that cigarette smoking and dust exposure each have an additive and compounded effect. Dr. Wright also found that coal workers' pneumoconiosis early category 1/0 could not be excluded and diagnosed old healed tuberculosis, status post thoracotomy with lobectomy, secondary to old healed tuberculosis, remote with no apparent sequela; and history of cardiac arrhythmia with implantation of cardiac pacemaker.

Based on his findings, Dr. Wright stated that he would advise Claimant against performing any activity where he might be exposed to further dust or noxious gases and that if Claimant were actively mining, he would recommend that Claimant retire and find other employment. Moreover, Dr. Wright opined that Claimant's pneumoconiosis was due to the inhalation of coal mine dust and stated that pneumoconiosis is a permanent condition that will worsen with continued exposure.

On the other hand, Dr. Wright conceded that the respiratory impairment he diagnosed was of a very mild degree and that Claimant's blood-gas studies and pulmonary function studies results did not qualify under the regulations. Moreover, Dr. Wright conceded that Claimant retained the functional respiratory capacity to perform the manual labor typically associated with working as an underground coal miner. Dr. Wright also conceded that one would not normally expect to find pulmonary impairment associated with simple stage 1 coal workers' pneumoconiosis and that there were conditions other than pneumoconiosis which could produce

Claimant's symptoms and what he viewed on Claimant's x-rays. On the other hand, Dr. Wright also stated that he believed coal workers' pneumoconiosis was the most probable cause of Claimant's complaints and x-ray changes.

In a supplemental report dated May 8, 1989, Dr. Wright opined that Claimant had an occupational lung disease caused by his coal mine employment and suffered from a mild impairment. Yet, Dr. Wright opined that Claimant's pulmonary impairment was not related to pneumoconiosis. Instead, Dr. Wright opined that Claimant's pulmonary impairment was secondary to smoking and tuberculosis. Dr. Wright also opined that Claimant had the pulmonary capacity to continue working as a coal miner or perform similar work in a dust-free environment.

Dr. Robert Penman (DX 1 at 452 (prior claim exhibit # DX 59 at 116, 145, 234, 258))

Dr. Penman, who is board-certified in internal medicine with a subspecialty in pulmonary disease, examined and wrote a report on his findings regarding Claimant on October 25, 1986. In that report, Dr. Penman opined that Claimant had stage I coal workers' pneumoconiosis and that Claimant's lung function was impaired. In a deposition taken May 20, 1987, Dr. Penman discussed his examination and opinions regarding Claimant. In his report, Dr. Penman noted claimant's occupational, medical, and smoking histories, symptoms, and findings based on Claimant's physical examination, chest x-rays, pulmonary function tests, and blood-gas tests.

In his deposition, Dr. Penman stated that Claimant's x-ray revealed fine nodulation in the lower and mid zones of both lungs consistent with stage I pneumoconiosis (1/1/ p) and that Claimant had a pacemaker in place. While Dr. Penman acknowledged that there were several other conditions that could mimic the changes he viewed on Claimant's x-ray, Dr. Penman further stated that he believed the history he obtained and his physical examination of Claimant went "a long way towards ruling out those other conditions."

In his deposition, Dr. Penman further stated that Claimant's blood-gas study showed hypoxia, which is a shortage of oxygen, with a reduced PO2 of 76.1. Yet, with regard to Claimant's hypoxia, Dr. Penman stated that Claimant's cigarette smoking certainly would have to be considered a factor and that Claimant's heart disease could also certainly be a factor. Dr. Penman stated that the only other possible cause of Claimant's hypoxia could be chronic bronchitis, which Dr. Penman acknowledged is typically related to cigarette smoking. On the other hand, Dr. Penman stated that coal miners showed an increased incidence of chronic bronchitis. Dr. Penman also stated that Claimant had a history consistent with that diagnosis, although he did not find any evidence of the condition in his examination of Claimant. Yet, elsewhere in his deposition, Dr. Penman said that Claimant had chronic bronchitis, and also that, assuming Claimant had bronchitis, he would attribute the condition, at least partially, to his chronic exposure to coal and rock dust.

With regard to Claimant's level of impairment, Dr. Penman stated that he did not find any significant respiratory impairment upon physical examination of Claimant and that Claimant's spirometry was normal. Moreover, Dr. Penman acknowledged that based on Claimant's spirometry results, he had the functional respiratory capacity to perform hard manual

labor, although he did note that Claimant had severe heart disease. On the other hand, Dr. Penman also stated that pneumoconiosis is not curable and that it is progressive, especially with continued exposure. Dr. Penman stated that his opinions were expressed with a reasonable degree of medical probability.

Dr. Bruce Broudy (DX 1 at 452, 998 (prior claim exhibit #'s DX 59 at 10, 159, DX 14))

Dr. Broudy, who is board-certified in internal medicine with a subspecialty in pulmonary medicine, examined Claimant on February 16, 1987. In a report dated February 17, 1987, Dr. Broudy noted Claimant's medical, smoking, and work histories, symptoms and that as part of his examination of Claimant, he performed a physical examination, arterial blood-gas study, which was normal, pulmonary function study, which revealed Claimant had a slight restrictive ventilatory defect, EKG, and chest x-rays, which showed no evidence of coal workers' pneumoconiosis.

Based on the foregoing, Dr. Broudy made the following diagnoses: permanent cardiac pacemaker; status post left thoracotomy and partial left lung resection. Dr. Broudy further opined that he believed Claimant's restrictive ventilatory defect, as revealed by the pulmonary function study results, could be due to Claimant's previous lung surgery and partial lung resection. Moreover, Dr. Broudy opined that he believed that Claimant retained the respiratory functional capacity to perform the work of an underground coal miner and that Claimant did not suffer from any significant pulmonary disease or respiratory impairment arising from his occupation as a coal miner.

Dr. Cordell Williams (DX 1 at 452 (prior claim exhibit # DX 59 at 246))

Dr. Williams, whose qualifications are unknown, examined and wrote a report regarding Claimant on April 21, 1987. In his report, Dr. Williams noted Claimant's employment, medical, and smoking histories. Dr. Williams also noted Claimant's symptoms in his report and, that as part of his examination, he physically examined Claimant, took a chest x-ray, and performed an EKG, pulmonary function study, and arterial blood-gas study.

Based on the foregoing, Dr. Williams diagnosed Claimant with chronic obstructive pulmonary disease with status following left lower lobe resection for tuberculosis. Dr. Williams explained that Claimant had some bullous emphysema, some increased bronchial markings in the right mid and lower lung zones compatible with 0/1 p/s pneumoconiosis. Dr. Williams also diagnosed arteriosclerotic heart disease with permanent pacemaker. Dr. Williams opined that Claimant's condition was related to coal mine dust exposure and that he felt Claimant suffered from a mild pulmonary impairment. On the other hand, Dr. Williams opined that Claimant's mild pulmonary impairment was due to Claimant's left lower lobectomy and that Claimant had the respiratory physiological capacity to perform the work of a coal miner in a non-dusty environment.

Dr. Emery Lane (DX 1 at 452 (prior claim exhibit # DX 59 at 16, 173))

Dr. Lane, who is board-certified in internal medicine, examined Claimant on June 3, 1987. In his report dated June 8, 1987, Dr. Lane noted that he considered Claimant's medical, smoking, and work histories as part of his examination of Claimant. Dr. Lane also noted Claimant's symptoms at the time of his examination, physically examined Claimant, took a chest x-ray, which revealed no opacities indicative of coal workers' pneumoconiosis, and performed an EKG, pulmonary function study, which rendered essentially normal results (class 1, 0% impairment), and a blood-gas study, which was normal. Based on the foregoing, Dr. Lane listed the following impressions: status post pulmonary tuberculosis, hypertension, hypertensive cardiovascular disease, symptoms suggestive of arteriosclerotic heart disease with angina pectoris, status post pacemaker placement, and no evidence of coal worker's pneumoconiosis.

Dr. John Harrison (DX 1 at 452 (prior claim exhibit # DX 59 at 12, 178))

Dr. Harrison, who is board-certified in internal medicine with a subspecialty in pulmonary disease, examined Claimant on June 23, 1987. That examination and Dr. Harrison's opinions are summarized in a report dated June 23, 1987. In that report, Dr. Harrison noted Claimant's work, smoking, and medical histories. Dr. Harrison also noted in his report what Claimant's symptoms were at the time of the examination and that he physically examined Claimant, took a chest x-ray, and performed pulmonary function and blood-gas tests. Dr. Harrison noted that Claimant's chest x-ray revealed extensive bullous emphysema throughout most of the entire left lung field and that the right chest also revealed some bullae in the base, although the rest of the lung field was clear without any evidence of pneumoconiosis.

Based on the foregoing, Dr. Harrison opined that there was no evidence that Claimant had coal workers' pneumoconiosis or a pulmonary disability related to that disease. Dr. Harrison noted that Claimant did have evidence of clubbing, which Claimant stated had been present all of his life, bullous emphysema, and a prior history of a lung abscess. Dr. Harrison opined that Claimant's subjective pulmonary complaints were related to bullous emphysema and that based on Claimant's lifelong history of clubbing and previous unknown lung disease requiring thoracotomy, Dr. Harrison suspected that Claimant may have a congenital abnormality. Moreover, Dr. Harrison opined that Claimant's process (bullous emphysema) was in no way related to coal mine dust exposure. Dr. Harrison also noted that Claimant's pulmonary function and arterial blood-gas test results, which were above federal standards for disability, indicated that Claimant had the respiratory capability to perform the work of an underground coal miner.

Dr. Glen Baker (DX 1 at 925 (prior claim exhibit; DX 18))

Dr. Baker, whose qualifications are unknown, examined and wrote a report regarding Claimant on August 25, 1994. As part of that examination, Dr. Baker conducted a physical examination, took a chest x-ray, and performed a pulmonary function study, and blood-gas study. Dr. Baker also noted Claimant's current symptoms and employment, medical, and smoking histories. Based on the foregoing, Dr. Baker diagnosed (1) based on Claimant's chest

x-ray, either tuberculosis or pneumoconiosis 2/1 with "A" large opacities caused by either tuberculosis or coal mine employment; (2) based on Claimant's pulmonary function study values, chronic obstructive pulmonary disease with mild obstructive defect caused by cigarette smoking and coal mining employment; and (3) based on Claimant's history of cough, sputum production and wheezing, chronic bronchitis caused by cigarette smoking and coal mining employment. Dr. Baker opined that Claimant had a mild impairment with a decreased FEV_1 and that each of his diagnoses fully contributed to Claimant's pulmonary impairment.

Dr. Bruce Broudy (DX 1 at 452, 921 (prior claim exhibit #'s DX 59 at 10, DX 19))

Dr. Broudy, board-certified in internal medicine with a subspecialty in pulmonary disease, examined and wrote a report regarding Claimant on November 1, 1994. In this evaluation, Dr. Broudy reviewed a report summarizing a prior evaluation of Claimant that he had performed on February 16, 1987. Dr. Broudy also noted Claimant's employment, medical, and smoking histories, symptoms at the time of examination, physically examined Claimant, took a chest x-ray, and performed a pulmonary function study and blood-gas study.

In his report, Dr. Broudy noted that Claimant's pulmonary function study values showed mild obstruction. With regard to the chest x-ray, Dr. Broudy noted an increase in interstitial opacities in the mid and upper lung zones compared to Claimant's chest x-ray taken on February 16, 1987 and that there now appeared to be a large opacity in the right upper lobe. Dr. Broudy further noted that these changes were compatible with silicosis or coal workers' pneumoconiosis, although he stated that it was "quite surprising that the disease apparently manifest[ed] itself on x-ray only after the patient had stopped working in the mines," and that "the degree of progression in 7 years [was] quite unusual." Dr. Broudy noted that these circumstances raised the possibility that some other disease was present and that he would certainly not rule out the possibility of tuberculosis or histoplasmosis as causes of the abnormalities. Dr. Broudy also diagnosed chronic bronchitis with mild chronic obstructive airways disease, although he opined that these conditions were related to Claimant's previous cigarette smoking. Moreover, Dr. Broudy opined that Claimant retained the respiratory capacity to perform the work of an underground coal miner or a job requiring a similar level of manual labor.

Dr. Ballard Wright (DX 1 at 452, 790 (prior claim exhibit #'s DX 59 at 33, DX 50))

Dr. Wright, who is board-certified in anesthesiology, examined Claimant on May 13, 1995 and on June 10, 1995. In formulating his opinions, Dr. Wright considered his October 11, 1986 report regarding Claimant. Dr. Wright also considered Claimant's employment, medical, and smoking histories, Claimant's symptoms at the time of examination, physically examined Claimant, took an x-ray, and performed several tests, including a pulmonary function study, blood-gas study, and an EKG.

Based on the foregoing, Dr. Wright, in a report dated May 13, 1995, opined that coal workers' pneumoconiosis could not be excluded and that Claimant had old healed tuberculosis, probably had silicotuberculosis, status post thoracotomy and left lower lobectomy for tuberculosis, chronic smokers' bronchitis, and heart rhythm abnormality. He opined that, based on Claimant's x-ray (1/2), Claimant had an occupational lung disease caused by his coal mine

employment and suffered from a mild impairment. Dr. Wright noted that in comparing his October 11, 1986 report to Claimant's x-ray taken on May 13, 1995, there was a marked and significant change in the upper lung zones which Dr. Wright, in 1986, had found to be free from nodulation. On the other hand, Dr. Wright also opined that Claimant's pulmonary impairment was probably related to Claimant's smoking history and was not sufficient to preclude mining.

In a subsequent examination of Claimant on June 10, 1995, Dr. Wright once again noted Claimant's social and medical histories, Claimant's symptoms, and performed the same tests on Claimant that he did in his May 13, 1995 examination.[31] At this time, Dr. Wright opined that category 1/2 simple coal workers' pneumoconiosis and silicotuberculosis could not be excluded and further diagnosed old healed tuberculosis, status post surgery remote, status post thoracotomy remote, chronic smokers' bronchitis, with mild to moderate functional impairment, and arteriosclerotic heart disease, status post pacemaker remote. Like in his earlier report, Dr. Wright again opined that based on Claimant's x-ray (1/2), Claimant had an occupational lung disease caused by his coal mine employment and suffered from a mild impairment. Yet, also like in his earlier report, Dr. Wright further opined that Claimant's pulmonary impairment, as shown by the pulmonary function study results, was related to Claimant's smoking history and may, in part, have been related to effort. Dr. Wright therefore opined that Claimant retained the pulmonary capability to do his usual coal mine employment or comparable work.

Dr. P. Raphael Caffrey (DX 1 at 433, 764 (prior claim exhibit #'s E2-2, DX 54))

On January 12, 1996, Dr. Caffrey, who is board-certified in pathology, reviewed several documents regarding Claimant including, multiple medical documents, a work history, x-ray reports, the reports of Dr. Broudy (11/1/94), Dr. Branscomb (11/29/95), and Dr. Wright (4/19/95), two surgical pathology reports, and eleven slides of tissues samples obtained by Dr. Mandanas by bronchoscopy on February 24, 1988 and June 22, 1988. After microscopically examining the slides, Dr. Caffrey made the following diagnoses: (1) based on examination of the February 24, 1988 slides, a mild amount of anthracotic pigment was identified within alveoli and the specimens were negative for coal workers' pneumoconiosis or any other occupational pneumoconiosis and (2) based on examination of the June 22, 1988 slides, a mild amount of anthracotic pigment was identified and, as well as, possible minimal interstitial fibrosis, focal, and moderate, chronic inflammation.

Thereafter, based on a review of all of Claimant's medical documents, Dr. Caffrey stated that he was unable to diagnose coal workers' pneumoconiosis or any other occupational pneumoconiosis. Dr. Caffrey noted that, "according to all the experts," simple coal workers' pneumoconiosis "does not progress once the patient has been removed from the coal mine and [Claimant had] not worked in the coal mines since 1986." Dr. Caffrey also noted that Claimant apparently has chronic bronchitis, which Dr. Broudy opined was due to Claimant's years of smoking cigarettes and that he did not have a significant pulmonary disability. Also, while Dr. Caffrey noted that Claimant had a pacemaker, tuberculosis and histoplasmosis, Dr. Caffrey opined that none of these conditions were related to the fact that Claimant was a coal miner. Overall, Dr. Caffrey stated that in his "best medical judgment at [that] time, Claimant did not

[31] In Dr. Wright's June 10, 1995 report, he noted that Claimant smoked a pack of cigarettes a day for eighteen years. Otherwise, the histories recounted in the two reports are fully consistent.

have coal workers' pneumoconiosis or any other occupational pneumoconiosis, although he did have evidence of exposure to coal dust, and that "the fact that he was a coal miner did not cause him pulmonary disability."

Dr. Grover Hutchins (DX 1 at 426, 760 (prior claim exhibit #'s E2-2, DX 55))

Dr. Hutchins, who is board-certified in pathology, reviewed biopsy slides of tissue samples obtained by Dr. Mandanas by bronchoscopy on February 24, 1988 and June 22, 1988. Dr. Hutchins, in a report dated January 28, 1996, noted Claimant's smoking, employment, and medical histories. Upon review of the eleven histologic slides that were available, Dr. Hutchins noted that three of the slides obtained by Dr. Mandanas on February 24, 1988, contained respiratory parenchyma and showed "a moderate amount of anthracotic pigment with associated birefringent silicate-type particles in perivascular and peribronchial tissues and within macrophages within airspaces." Yet, because Dr. Hutchins noted that there were no macules, micronodules, or macronodules of coal workers' pneumoconiosis, he concluded that coal workers' pneumoconiosis was not demonstrated. On the other hand, Dr. Hutchins also noted that "only a small amount of lung tissue was demonstrated on these slides," and that the remaining eight slides showed nothing of significance. Dr. Hutchins stated that his opinion that the Claimant did not have pneumoconiosis was made with a reasonable degree of medical certainty. Dr. Hutchins also stated that, because Claimant did not have coal workers' pneumoconiosis, the disease could not have contributed to any pulmonary or respiratory impairment or disability that Claimant may have been suffering from.

Dr. Ben Branscomb (DX 1 at 332, 421, 780 (prior claim exhibit #'s E2- 3, E2-2, DX 51))

Dr. Branscomb, who is board-certified in internal medicine and has extensive experience in the field of pulmonary medicine, reviewed several of the x-rays reports, pulmonary function studies, blood-gas studies, physicians' reports, and medical records of Claimant that were submitted as part of Claimant's two prior claims filed on April 1, 1987 and July 7, 1994. Based on these records, Dr. Branscomb was able to determine Claimant's employment, medical, and smoking histories. From these records, Dr. Branscomb was also able to determine to some extent the duration and scope of Claimant's pulmonary complaints. In two reports dated November 29, 1995 and July 11, 1996, Dr. Branscomb summarized this information as well as his opinions regarding Claimant's pulmonary health. Additionally, in this case, Dr. Branscomb also reviewed Claimant's x-rays dated August 21, 1994 and November 1, 1994 and summarized his findings in a report dated July 17, 1996. By deposition testimony taken on July 22, 1996, Dr. Branscomb reviewed his qualifications, summarized the medical evidence he reviewed and discussed his findings and opinions which were summarized in his three reports.

At the deposition, Dr. Branscomb discussed his opinion that Claimant did not have "coal workers' pneumoconiosis or other occupational pulmonary disease" or "any pulmonary impairment secondary to the inhalation of dust in or around coal mines." Although Dr. Branscomb acknowledged that Claimant's exposure history was sufficient for Claimant to acquire coal workers' pneumoconiosis, assuming that the necessary dust conditions were present and Claimant was susceptible to the disease, Dr. Branscomb opined that x-ray abnormalities and Claimant's symptoms were caused by other conditions. Specifically, Dr. Branscomb noted that

Claimant had suffered from extensive acute histoplasmosis infection and that the changes viewed in Claimant's x-rays appeared to greatly correlate with the progression of that condition. At his deposition, Dr. Branscomb testified that tuberculosis and histoplasmosis "are very chronic slow diseases, and very often … leave areas of lung with a lot of little emphysematous air spaces, and later these can get infected, either with different organisms or the original organism can flare up in them." Dr. Branscomb further stated that there is "a lifelong history of cavitary lung disease or infected cystic areas or bullie, and of course scarring is sort of typical and usual after active pulmonary tuberculosis or histoplasmosis." Based on the foregoing evidence, Dr. Branscomb opined that the changes on Claimant's x-rays supported a finding of either histoplasmosis or tuberculosis. In his November 29, 1995 report, Dr. Branscomb noted that Claimant "had a remarkably successful recovery from extensive acute histoplasmosis infection. He further noted that there was a "remote history of probable active tuberculosis although this left no residual x-ray changes in the lung prior to the acute pneumonia and histoplasmosis."

Dr. Branscomb further noted in his November 29, 1995 report that Claimant seemed to have mild chronic bronchitis and mild expiratory obstruction, although he related these conditions to Claimant's prior cigarette smoking. Dr. Branscomb noted in his report and deposition that someone with Claimant's history of tobacco use would encounter an increased prevalence of smoking related pulmonary and cardiovascular disorders. On the other hand, notwithstanding the foregoing, Dr. Branscomb opined that, from a pulmonary standpoint, Claimant was capable of working as an underground coal miner or performing work requiring a similar level of exertion. In his November 29, 1995 report, Dr. Branscomb noted that the vast majority of Claimant's pulmonary function and blood-gas study test results were normal.

F. Hospitalization and Treatment Records (DX 1 at 901, 929, 936, 966 (prior claim exhibit #'s 26, 17, 16, 15))

Claimant's hospitalization and treatment records document replacement of his cardiac pacemaker (DX 1 at 929 (DX 17)) and treatment for histoplasmosis (DX 1 at 901, (DX 26). Claimant's cardiac pacemaker replacement records, dated November 11 through 14, 1993, document Claimant's past medical history of tuberculosis and right lung lobectomy in 1968, cardiac pacemaker implantation in 1986, histoplasmosis, emphysema/black lung, chronic dyspnea on exertion since 1968 after lobectomy, and tachycardia. At that time, it was noted that Claimant suffered from chronic cough with clear sputum production and chronic dyspnea on exertion and occasional wheezing when lying down. Claimant stated that he did not suffer from shortness of breath, chest pain, palpitations, orthopnea, or paroxysmal nocturnal dyspnea. The records note that at that time, Claimant was smoking approximately four to five cigarettes per day and had been doing so for the last year to year and a half.

Claimant's records for histoplasmosis treatment, dated February 21 through November 23, consist of several chest x-ray reports, laboratory results, pathology reports, bronchoscopy reports, and treatment notes by Dr. Rene Mandanas. These records are summarized in Dr. Mandanas' November 23, 1988 treatment note, which documents that Claimant suffered from a prolonged upper respiratory infection in January, which was thought to be pneumonia with a left upper lobe lung abscess by his treating physician. Claimant was admitted for treatment by Dr. Mandanas on February 23, 1988 and discharged on February 26, 1988.

In February 1988, on examination upon discharge, Dr. Mandanas noted that Claimant coughed daily, had occasional chest pains in the left axillary area, was not wheezing, had some shortness of breath, dyspnea, and that Claimant's lungs were relatively clear with occasional rhonchi noted in the left upper chest area. Prior to discharge, a bronchoscopy and transbronchial lung biopsy were performed, which revealed only mild fibrosis with focal edema, as well as anthrosilicosis and that the cultures for acidfast bacilli were negative. On follow-up, it was found that Claimant's left upper lung disease re-exacerbated and antibiotics were restarted in the hospital with improvement.

In June 1988, a follow-up revealed new infiltrate in Claimant's right mid lung field. At this time, there was resolution of the left upper lobe infiltrate, although persistent left apical pleural thickening and some cystic changes in that area were noted. Also at that time, a repeat bronchoscopy and biopsy were performed and tuberculosis treatment was restarted. Infiltrates in the right mid lung field were noted to then be somewhat improved, although new nodular infiltrate was noted in Claimant's left lower lobe in July 1988.

Thereafter, around August 23, 1988, a bronchial wash grew histoplasma capsulatum after prolonged intubation. Claimant received treatment and claimed to be much improved. On October 24, 1988, Claimant complained of persistent coughing and expectoration of yellowish phlegm. A chest x-ray showed minimal new infiltrates in the left lower lung field. A complement fixation for histoplasma indicated active infection and the sputum for histoplasma was positive. Claimant was told to increase the dose of his medication.

On November 23, 1988, Dr. Mandanas noted, in a treatment note dated December 1, 1988, that Claimant had experienced an increase in expectoration of yellowish phlegm for approximately a week, Claimant's lungs revealed decreased breath sounds bilaterally with rhonchi in both lung fields with no wheezing noted, that Claimant's chest x-ray revealed small but new infiltrates in the Claimant's right upper lung field, and it was felt that Claimant had persistent chronic cavitary histoplasmosis of the lung, status post pulmonary tuberculosis infection with treatment, status post left upper lobectomy by history, history of chronic obstructive pulmonary disease and pneumoconiosis with chronic bronchitis, acute bronchitis, and history of arteriosclerotic heart disease, status post inferior wall myocardial infarction. Dr. Mandanas also notes that treatment for tuberculosis was stopped at that time because Claimant had been treated for nearly six months for the condition and there was no evidence of the condition with repeated cultures.

The Standard for Entitlement

In this case, because Claimant filed his current claim more than one year after his last claim for benefits, Claimant must demonstrate that "one of the applicable conditions of entitlement has changed since the date upon which the order denying [his] prior claim became final." 20 C.F.R. § 725.309(d). The amended regulations specifically state that the "applicable conditions of entitlement shall be limited to those conditions upon which the prior denial was based." 20 C.F.R. § 725.309(d)(2).

In the Sixth Circuit, to assess whether a change is established, the Administrative Law Judge ("ALJ") "must consider all of the new medical evidence obtained after the previous denial, both favorable and unfavorable, and determine whether the miner has proven at least one of the elements of entitlement previously adjudicated against him." *See Tennessee Consolidated Coal Co. v. Kirk*, 264 F.3d 602, 608 (6th Cir. 2001) (citing *Sharondale v. Ross*, 42 F.3d 993, 997-98 (6th Cir. 1994)) (adjudicating a claim filed under the old regulatory provisions effective prior to January 1, 2001, which required a "material change in condition"). The ALJ must then determine whether the miner has proven that the new medical evidence "is substantially more supportive" of the miner than the evidence developed and considered in adjudicating his prior claim. *See Id.* at 609 (citing *Sharondale*, 42 F.3d at 998). In doing so, the miner must only prove that the new evidence is substantially more supportive of his claim: the miner does not need to prove a complete absence of evidence at the earlier time, rather he merely must prove that there is a substantial difference between the new and old evidence being considered by the court. *See Id.* at 610 (referring to standard set forth in *Sharondale*).

If the Claimant successfully establishes that one of the applicable conditions of entitlement has changed since the denial of his prior claim, the Presiding Judge must then consider whether all of the record evidence, including evidence submitted as part of Claimant's prior claims, supports an award of benefits under the Act. *Sharondale v. Ross*, 42 F.3d 993, 997-98 (6th Cir. 1994). In this case, Claimant filed his claim after April 1, 1980. Therefore, this claim is governed by the regulations at 20 C.F.R. Part 718. Under Part 718, Claimant bears the burden of establishing each of the following elements by a preponderance of the evidence: (1) Claimant has pneumoconiosis; (2) the pneumoconiosis arose out of coal mine employment; (3) Claimant is totally disabled; and (4) the pneumoconiosis contributes to Claimant's total disability. 20 C.F.R. §725.202(d)(2). Failure to establish any one of these elements precludes entitlement to benefits.

I. Change in a Condition of Entitlement

In Claimant's last federal black lung claim, the ALJ found that Claimant had proven by a preponderance of the evidence that he had pneumoconiosis as defined by the Act.[32] (DX 1 at 202-16.) On the other hand, the ALJ found that Claimant had not proven that he was totally disabled.[33] (DX 1 at 72-85.) Accordingly, the ALJ made no findings regarding whether Claimant's total disability was caused by Claimant's pneumoconiosis. Therefore, in the instant case, in order to have his subsequent claim adjudicated, the Claimant must prove by a preponderance of the new evidence that he is totally disabled. Moreover, Claimant must also prove that the new evidence is substantially more supportive of his claim than the evidence submitted as part of his prior claims.

[32] This finding was affirmed by the Benefits Review Board and was thereafter not challenged. (DX 1 at 1-5, 133-37.)

[33] The Administrative Law Judge's finding that the Claimant was not totally disabled based on pulmonary function study, blood-gas study, cor pulmonale, or physician opinion evidence. was not appealed and his finding that Claimant was not totally disabled because he did not have complicated pneumoconiosis, although appealed, was affirmed by the Benefits Review Board and the Sixth Circuit Court of Appeals. (DX 1 at 1-5, 26-34.)

A. Total Disability

Benefits are provided under the Act for, or on behalf of, miners who are totally disabled due to pneumoconiosis. 20 C.F.R. § 718.204(a). In determining whether a miner is totally disabled due to pneumoconiosis, the regulations state that "any nonpulmonary or nonrespiratory condition or disease, which causes an independent disability unrelated to the miner's pulmonary or respiratory disability, shall not be considered[,]" but "[i]f, however, a nonpulmonary or nonrespiratory condition or disease causes a chronic respiratory or pulmonary impairment, that condition or disease shall be considered in determining whether the miner is or was totally disabled due to pneumoconiosis." 20 C.F.R. § 718.204(a). Moreover, the regulations also state that a miner shall be considered totally disabled if the irrebuttable presumption prescribed in 20 C.F.R. § 718.304 applies or if the miner has a pulmonary or respiratory impairment which, standing alone, prevents the miner from performing his usual coal mine work and also prevents the miner from engaging in other employment requiring skills and abilities comparable to those used by the miner, "with some regularity over a substantial period of time," while he worked as a miner. 20 C.F.R. § 718.304(b)(1).

Twenty C.F.R. § 718.204(b) provides the following five methods for establishing total disability: (1) 20 C.F.R. § 718.304 irrebuttable presumption; (2) qualifying pulmonary function studies; (3) qualifying blood gas studies; (4) evidence of cor pulmonale with right-sided congestive heart failure;[34] and (5) reasoned medical opinions.[35]

20 C.F.R. § 718.304 Irrebuttable Presumption

The regulations provide for an irrebuttable presumption of total disability due to pneumoconiosis if a miner is suffering or suffered from a chronic dust disease of the lung which: (a) when diagnosed by x-ray, yields opacities greater than one centimeter in diameter that would be classified in Category A, B, or C; (b) when diagnosed by biopsy or autopsy, yields massive lesions in the lung; or (c) when diagnosed by means other than x-ray, biopsy, or autopsy, yields findings which could reasonably be expected to yield the results described in (a) or (b) had diagnosis been made as therein described: provided, however, that acceptable medical procedures are used. 20 C.F.R. § 718.304.

In the Sixth Circuit's unpublished Order rendered in Claimant's last claim filed under the Act, the Sixth Circuit set forth Claimant's burden of proof for invoking the presumption in 20 C.F.R. § 718.304:

> The claimant has the burden of proof in establishing the existence of complicated pneumoconiosis and thereby invoking the irrebuttable presumption of total disability. A chronic dust disease must be established in order to invoke the presumption, and x-ray evidence will not automatically trigger the presumption

[34] There is no evidence of cor pulmonale with right-sided congestive heart failure such that this method of establishing total disability will not be discussed further.

[35] The Board holds that a judge cannot rely solely upon lay evidence to find total disability in a living miner's claim. *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103 (1994).

> when conflicting evidence exits. Other evidence may affirmatively show that the large opacities found on x-rays are not what they appear to be.

Sexton v. Switch Energy Coal Corp., No. 00-4451, slip op. at 4 (6th Cir. Sep. 18, 2001) (internal citations omitted).

In this case, there are three chest x-rays in the record. The first chest x-ray is dated March 18, 2003 and was read by Dr. Baker, a B-reader, Dr. Dahhan, a B-reader, and Dr. Alexander, a dually qualified board-certified radiologist and B-reader. Drs. Baker and Alexander both read this x-ray as positive for large opacities: Dr. Alexander noted an A opacity and Dr. Baker noted a "B" opacity, although he wrote on his report dated March 18, 2003, that he questioned whether the x-ray abnormalities might be secondary to tuberculosis. Conversely, Dr. Dahhan interpreted this x-ray as negative for large opacities. Dr. Dahhan testified at his deposition that he did not observe any masses of one centimeter or larger on Claimant's x-rays consistent with pneumoconiosis or any other disease or condition. Accordingly, based on the fact that two physicians, one of whom is dually qualified, found that this x-ray is positive for large opacities, the Presiding Judge finds that this x-ray shows a large type "A" opacity. In this case, the Presiding Judge notes that Dr. Alexander's credentials are superior to those of Dr. Baker's and therefore accords his opinion more weight.

The second x-ray in this case is dated April 24, 2003 and was read by Dr. Dahhan, who read the x-ray as negative for large opacities, and Dr. Alexander, who read the x-ray as positive for type B large opacities. As previously noted, Dr. Dahhan observed no large opacities when he read Claimant's x-ray that were either consistent with pneumoconiosis or any other condition or disease. Moreover, also as previously discussed, Dr. Alexander's credentials are superior to those of Dr. Dahhan. Accordingly, the Presiding Judge accords Dr. Alexander's interpretation of the x-ray more weight and therefore finds that the x-ray is positive for large type B opacities.

The final x-ray in this case is dated June 19, 2003 and was read by Dr. Fino, who is a B-reader, as negative for large opacities, and by Dr. Alexander as positive for type B large opacities. Here again, the Presiding Judge notes that Dr. Alexander's qualifications are superior to those of Dr. Fino's. On the other hand, unlike Dr. Dahhan, Dr. Fino noted that he saw mass-like abnormalities revealed in the x-ray, although he did not classify the masses as large opacities indicative of complicated pneumoconiosis. Instead, based on his knowledge of Claimant's medical history, Dr. Fino opined that the changes were consistent with Claimant's history of tuberculosis. Yet, in this case, the Presiding Judge notes that there is no evidence in the record that definitively confirms that the large masses in Claimant's lung are attributable to either pneumoconiosis or tuberculosis. Accordingly, notwithstanding the fact that Dr. Fino apparently had actual knowledge of Claimant's medical history when he read the x-ray, the Presiding Judge finds that the x-ray is positive for large type B opacities. The Presiding Judge notes that the fact that Dr. Fino apparently relied on his knowledge of Claimant's medical history in interpreting Claimant's x-ray is not evidence that Dr. Alexander, who is both a B-reader and a board-certified radiologist, without similar knowledge, could not distinguish between abnormalities on Claimant's x-ray indicative of pneumoconiosis from abnormalities indicative of tuberculosis. Overall, while Dr. Fino's analysis raises the possibility that the large mass in Claimant's upper right lung could be due to a disease process other than pneumoconiosis, in light of the fact that

Dr. Fino is only a B-reader and there is no objective evidence in the record confirming that the large mass is due to tuberculosis, the Presiding Judge finds that Dr. Fino's explanation of the x-ray findings is insufficient to rebut the x-ray interpretations by the highly qualified Dr. Alexander, which are supported by the interpretation by Dr. Baker, whose qualifications are equal to those of Dr. Fino.

Accordingly, based on the foregoing, the Presiding Judge finds that the preponderance of the x-ray evidence is positive for complicated pneumoconiosis. Turning next to the new biopsy evidence and other evidence of record, the Presiding Judges notes that, while this evidence does not definitively demonstrate that Claimant has complicated pneumoconiosis, the Presiding Judge also notes that this evidence is not inconsistent with the x-ray evidence. With regard to the biopsy evidence, the Presiding Judge notes that, although Dr. Skelly noted the presence of anthracotic pigment in Claimant's lungs, he described neither large masses nor massive lesions in his report. On the other hand, the Presiding Judge notes that the tissue samples were taken from Claimant's left lower lung and the large opacity identified in Claimant's x-rays is noted to be in Claimant's upper right lung. Accordingly, the Presiding Judge finds that the biopsy evidence neither proves nor disproves that Claimant has a chronic dust disease of the lung.

Now turning to the matter of whether the record contains evidence that Claimant has been diagnosed with a chronic dust disease of the lung based on the fact that other acceptable medical procedures yielded findings similar to either large masses or massive lesions, the Presiding Judge notes that there is no such other evidence in the record. While the Presiding Judge notes that there are other x-rays and a CT scan in the record, the x-rays do not substantially comply with the quality standards prescribed in 20 C.F.R. §718.102 and Claimant has not proven that the CT scan is a medically acceptable test or procedure as required under 20 C.F.R. §718. 107. Moreover, while the Presiding Judge notes that the x-rays and CT scan indicate that there are in fact one or more large masses present in Claimant's upper lung zones, they do not indicate what the masses represent, i.e. whether the masses are caused by a chronic dust disease of the lung or some other disease process. As a result, the Presiding Judge finds that there is no other evidence in the record that either proves or disproves that Claimant has a chronic dust disease of the lung.

Accordingly, after considering the new x-ray evidence, new biopsy evidence, and other new evidence of record, the Presiding Judge finds that Claimant has proven by a preponderance of the new evidence that he suffers from complicated pneumoconiosis and, therefore, is entitled to invoke the 20 C.F.R. §718.304 irrebuttable presumption that he is totally disabled due to pneumoconiosis. On the other hand, after comparing the new evidence with the old evidence, the Presiding Judge cannot say that there is a substantial difference between the new evidence and the old evidence presented in this case. Specifically, the Presiding Judge notes that in Claimant's prior claim, two dually qualified physicians and two B-readers identified large opacities in Claimant's x-rays, while two dually qualified physicians, a B-reader, and a physician with unknown qualifications found no evidence of large opacities on Claimant's x-rays. In Claimant's current claim, one dually qualified physician and one B-reader identified a large opacity on Claimant's x-ray while two B-readers found no evidence of complicated pneumoconiosis. Overall, the Presiding Judge finds that there still appears to be quite a bit of debate among the highly qualified physicians in this case over whether Claimant's x-rays do in fact reveal large opacities consistent with pneumoconiosis. As a result, the Presiding Judge finds

that the new evidence is substantially the same as the old evidence. Accordingly, the Presiding Judge finds that Claimant has not proven, in this instance, that there has been a change in an element of entitlement as required under 20 C.F.R. § 725.309(d).

Pulmonary Function Studies

Total disability may be established through a preponderance of qualifying pulmonary function studies. The quality standards for pulmonary function studies are located at 20 C.F.R. § 718.103 and require, in relevant part, that (1) each study be accompanied by three tracings, *Estes v. Director, OWCP*, 7 B.L.R. 1-414 (1984), (2) the reported FEV_1 and FVC or MVV values constitute the best efforts of three trials, and, (3) for testing conducted after January 19, 2001, a flow-volume loop be provided. In weighing the studies, the administrative law judge may accord less probative value to those studies where the miner exhibited "poor" cooperation or comprehension. *Runco v. Director, OWCP*, 6 B.L.R. 1-945 (1984).

As summarized above, of the new evidence submitted in this claim, only one of the conforming pulmonary function studies, that of Dr. Baker, qualifies under the regulations. The results in the remaining two conforming studies, by Drs. Dahhan and Fino, do not qualify. Accordingly, the Presiding Judge finds that Claimant has failed to prove he is totally disabled pursuant to 20 C.F.R. § 718.204(b)(2)(i) based on the new conforming pulmonary function studies admitted into the record.

Arterial Blood-gas Studies

Total disability may also be established by qualifying blood-gas studies under 20 C.F.R. § 718.204(b)(2)(ii). To be qualifying, the PO2 values corresponding to the PCO2 values must be equal to or less than those found in the applicable table in Appendix C of 20 C.F.R. Part 718.

In this case, as previously summarized in this Decision, none of the new arterial blood-gas study results qualify under the regulations. Accordingly, the miner has not demonstrated total disability pursuant to 20 C.F.R. § 718.204(b)(2)(ii) based on a preponderance of the blood-gas study evidence in this case.

Medical Opinion Evidence

The final method by which Claimant may establish total disability is through medical opinion evidence, wherein a physician has exercised reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, to conclude that the miner's respiratory or pulmonary condition prevents him from engaging in his usual coal mine or comparable employment. 20 C.F.R. § 718.204(b)(2)(iv).

Initially, a claimant has the burden of establishing the exertional requirements of his usual coal mine employment. *Onderko v. Director, OWCP*, 14 B.L.R. 1-2 (1989). Once a claimant establishes that he is unable to perform his usual coal mine employment, a *prima facie* case for total disability exists and the burden shifts to the party opposing entitlement to prove

that the claimant is able to perform comparable and gainful work. *Taylor v. Evans and Grambrel Co.*, 12 B.L.R. 1-83, 1-87 (1988).

As previously discussed, the Parties have stipulated that Claimant's work as a miner constituted heavy labor. As a miner, Claimant was required to lift bags of rock dust and cement, build brattices, and move equipment such as motors for shuttle cars. Accordingly, based on the foregoing, the Presiding Judge finds that Claimant has established that the exertional requirements of his usual coal mine employment entailed heavy labor.

Moreover, based on the evidence of record, Claimant has also established that he no longer has the pulmonary capacity to perform his usual coal mine employment. In this case, all three physicians who examined Claimant expressed opinions regarding Claimant's level of disability, from a pulmonary standpoint. Drs. Baker and Fino opined that Claimant is totally disabled and cannot perform heavy labor. Additionally, although Dr. Dahhan initially opined in his report that Claimant retains the physiological capacity to continue his previous coal mining work or a job of comparable physical demand, when he was told claimant's job required heavy labor, Dr. Dahhan conceded that, based on Claimant's FEV_1 value, it was questionable whether Claimant could in fact perform such work.

After reviewing the evidence upon which the physician's relied in rendering their opinions, the Presiding Judge finds that all three opinions are well-reasoned medical judgments that are based on, and supported by, objective medical evidence. Specifically, the Presiding Judge finds that in rendering their opinions, all three physicians physically examined Claimant and fully considered the relevant aspects of Claimant's employment, smoking, and medical histories, respiratory symptoms, and the results of objectively credible medical tests. Accordingly, the Presiding Judge finds that these opinions are well-documented. Moreover, the Presiding Judge finds that these physicians' opinions are also well-reasoned, because the underlying documentation relied upon supports the opinions. In this case, all three physicians noted that they heard irregular sounds while examining Claimant's lungs, noted abnormalities in Claimant's chest x-rays, considered Claimant's subjective pulmonary complaints and medical history, and considered the results of Claimant's blood-gas and pulmonary function studies. While the Presiding Judge notes that none of the blood-gas study results are qualifying under the regulations and that only the results rendered in Dr. Baker's pulmonary function study qualify under the regulations, based on the FEV_1/FVC ratio, the Presiding Judge also notes that the values rendered in Dr. Dahhan's and Dr. Fino's pulmonary function studies are close to qualifying. Moreover, the Presiding Judge also notes that all three physicians diagnosed Claimant with at least a mild respiratory impairment and that the physicians' opinions and the medical evidence upon which they relied in rendering their opinions are consistent with the other evidence of record (i.e. Claimant's testimony regarding his current exertional ability and Claimant's hospitalization and treatment records).

Accordingly, based on the foregoing, the Presiding Judge finds that Claimant has established that he no longer has the pulmonary capacity to perform his usual coal mine employment. Therefore, because in this case there is no evidence demonstrating that Claimant is able to perform comparable and gainful work, the Presiding Judge finds that Claimant has proven by a preponderance of the new medical opinion evidence that he is totally disabled.

Furthermore, the Presiding Judge also finds that the new medical evidence submitted as part of the current claim is substantially more supportive of Claimant's case than the medical evidence submitted as part of Claimant's prior claims. Specifically, the Presiding Judge notes that, while several physicians who diagnosed Claimant with coal workers' pneumoconiosis advised claimant to avoid coal mine dust, no physician opined that Claimant lacked the pulmonary capability to perform the work of a coal miner or work requiring a comparable level of exertion in a dust-free environment. Accordingly, for the foregoing reasons, the Presiding Judge finds that Claimant has proven by a preponderance of the evidence that there has been a change in an element of entitlement as required under 20 C.F.R. § 725.309(d).

II. Full Review of the Record

A. Elements 1 and 2: Existence of Pneumoconiosis and its Etiology

Pneumoconiosis is defined as a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." 20 C.F.R. § 718.201(a). The disease is recognized as being "a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure." 20 C.F.R. § 718.201(c). Under the amended regulations, the definition of pneumoconiosis includes both clinical and legal pneumoconiosis:

> (1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconiosis, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.
>
> (2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

20 C.F.R. § 718.201(a)(1)-(2). For the purpose of defining pneumoconiosis, "a disease 'arising out of coal mine employment' includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment." 20 C.F.R. § 718.201(b). The regulations at 20 C.F.R. § 718.203(b) further provide that, if a miner suffers from pneumoconiosis and has engaged in coal mine employment for ten years or more, there is a rebuttable presumption that the pneumoconiosis arose out of such employment. In the Sixth Circuit, when this rebuttable presumption does not apply, a Claimant must establish that his pneumoconiosis arose "in part" from his coal mine employment. *Southard v. Director, OWCP*, 732 F.2d 66, 6 B.L.R. 2-26 (6th Cir. 1984).

The existence of pneumoconiosis may be established by any one or more of the following methods: (1) chest x-rays; (2) autopsy or biopsy; (3) by operation of presumption; or (4) by a physician exercising sound medical judgment based on objective medical evidence.[36] 20 C.F.R. § 718.202(a).

Chest x-rays

When weighing chest x-ray evidence, the provisions at 20 C.F.R. § 718.202(a)(1) require that "where two or more x-ray reports are in conflict, in evaluating such x-ray reports consideration shall be given to the radiological qualifications of the physicians interpreting such x-rays." In this vein, the Board has held that it is proper to accord greater weight to the interpretation of a B-reader or board-certified radiologist over that of a physician without these specialized qualifications. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211 (1985); *Allen v. Riley Hall Coal Co.*, 6 B.L.R. 1-376 (1983). Moreover, an interpretation by a dually-qualified B-reader and board-certified radiologist may be accorded greater weight than that of a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211 (1985); *Sheckler v. Clinchfield Coal Co.*, 7 B.L.R. 1-128 (1984).

As previously mentioned, the regulations state that pneumoconiosis is recognized as "a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure." 20 C.F.R. § 718.201(c). Accordingly, under the circumstances of this case, where (1) the x-rays submitted as part of Claimant's two prior claims predate the x-rays submitted as part of the current claim by at least seven and a half years and (2) where a review of the record demonstrates that Claimant's condition has in fact progressed over the years, the Presiding Judge finds that the x-rays and corresponding interpretations submitted as part of Claimant's current claim provide the most probative evidence regarding whether Claimant has pneumoconiosis and accords those x-rays and interpretations greater weight. *Crace v. Kentland-Elkhorn Coal Corp.*, 109 F.3d 1163 (6th Cir. 1997); *Woodward v. Director*, OWCP, 991 F.2d 314 (6th Cir. 1993); *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989)(en banc); *Stanford v. Director, OWCP*, 7 B.L.R. 1-541 (1984); *Tokarcik v. Consolidation Coal Co.*, 6 B.L.R. 1-666 (1983).

In this case, seven conforming x-ray interpretations of three x-rays were submitted as part of Claimant's current claim. Of these reports, all but one stated that the x-rays revealed evidence of pneumoconiosis. Of these six positive x-ray interpretations, (1) four stated that there is evidence of complicated pneumoconiosis, (2) four stated that there is evidence of category II simple pneumoconiosis, and (3) two found evidence of only category I simple pneumoconiosis. After comparing the physician's radiological qualifications, the Presiding Judge makes the following findings regarding the most recent x-rays in the record: the March 18, 2003 x-ray, April 24, 2003 x-ray, and June 19, 2003 x-ray all show evidence of complicated and category II simple pneumoconiosis.[37] Accordingly, the Presiding Judge now turns to reviewing the evidence

[36] There is no autopsy evidence in the record. Accordingly, this method of establishing pneumoconiosis will not be discussed further in this Decision.

[37] In reconciling the interpretations of the March 18, 2003 x-ray, in addition to the physicians' radiological qualifications, the Presiding Judge also took into consideration the number of physicians who read the film as positive for category I versus category II pneumoconiosis. Two physicians read the film as 2/2, while only one physician read the film as 1/0. For further discussion regarding the Presiding Judge's analysis of the most recent x-

from Claimant's prior claims to determine whether the preponderance of the x-ray evidence demonstrates that Claimant has pneumoconiosis.

Turning first to the issue of whether Claimant has complicated pneumoconiosis, the evidence shows that the mass in Claimant's right upper lung, which has been diagnosed as complicated pneumoconiosis, was not present prior to June 23, 1987, the date the last x-ray submitted as part of Claimant's April 1, 1987 claim was taken. Accordingly, the x-ray evidence submitted as part of Claimant's April 1, 1987 claim is not relevant in this instance and will not be further considered. Turning next to the evidence submitted as part of Claimant's July 7, 1994 claim, the Presiding Judge notes that the record evidence shows that there has been no significant change in the large mass found in Claimant's upper right lung since the time he filed his second claim. Accordingly, the Presiding Judge finds that the evidence submitted as part of Claimant's second claim relating to the mass in Claimant's upper right lung is relevant and probative of whether Claimant has complicated pneumoconiosis and therefore is entitled to full consideration.

In Claimant's second claim, two dually qualified physicians and two B-readers observed a large opacity on Claimant's x-rays. Of these physicians, both B-readers, Drs. Baker and Broudy, questioned whether the opacity was in fact indicative of pneumoconiosis,[38] and Dr. Barrett questioned whether the opacity might be cancer. Moreover, both dually qualified physicians, Drs. Barrett and Wiot, noted in their reports that they observed evidence of other abnormalities on Claimant's x-rays.[39]

Claimant's second claim also includes several negative x-ray interpretations. Dr. Sargent, who is dually qualified as a board-certified radiologist and a B-reader, read Claimant's x-rays as negative for large opacities. Dr. Sargent noted that it was necessary to differentiate between old granulomatous disease and pneumoconiosis. Additionally, Dr. Branscomb, a B-reader, and Dr. Wright, whose qualifications are unknown, also read Claimant's x-rays as negative for large opacities.

Other relevant evidence from Claimant's second claim includes medical records documenting Claimant's treatment for a histoplasmosis infection and the reports and deposition testimony by Dr. Branscomb. This evidence shows that Claimant was thought to have suffered from tuberculosis in the late 1960's and that a portion of Claimant's left upper lung was removed as treatment for this condition in 1968. The record also demonstrates that in 1988, Claimant suffered from a severe histoplasmosis infection. Based on the foregoing information and an extensive review of other evidence in the record, Dr. Branscomb, who is board-certified in internal medicine, has extensive experience in the field of pulmonary medicine, and is a B-reader, opined that the abnormalities observed on Claimant's x-rays were the result of Claimant's

---

rays for complicated pneumoconiosis see the discussion in the 20 C.F.R. § 718.304 Irrebuttable Presumption section, supra.

[38] Dr. Baker questioned whether the abnormalities he observed in Claimant's x-ray were caused by tuberculosis. Dr. Broudy questioned whether the abnormalities were indicative of some other disease process, based in part on his opinion that it was surprising that Claimant's disease manifested itself on x-ray only after Claimant stopped working in the mine and that the degree of progression that occurred over seven years was quite unusual.

[39] Dr. Barrett noted evidence of old granuloma on his x-ray report. Dr. Wiot noted on his report that he observed changes in Claimant's left lung that were consistent with an old inflammatory process that was most likely old pulmonary tuberculosis.

prior tuberculosis and histoplasmosis infections rather than pneumoconiosis. In his report dated November 29, 1995, Dr. Branscomb noted that histoplasmosis is a fungus disease that produces changes which "resemble both [tuberculosis] and sometimes [coal workers' pneumoconiosis]." In a deposition taken on July 22, 1996, Dr. Branscomb explained that tuberculosis and histoplasmosis are very chronic slow diseases that often leave a lot of little emphysematous air spaces in areas of the lung. Dr. Branscomb further stated that there is a lifelong history of cavitary lung disease or infected cystic areas or bullie associated with these conditions and that there is also often course scarring, which is "typical and usual" after one has active pulmonary tuberculosis or histoplasmosis.

Considering the evidence from Claimant's second claim, the Presiding Judge finds that the preponderance of all x-ray evidence does not demonstrate that Claimant has complicated pneumoconiosis. Specifically, based on Claimant's medical records, Dr. Branscomb's well-documented and well-reasoned opinions, the lack of any objective medical evidence in the record confirming that Claimant has complicated pneumoconiosis, and the fact that Dr. Sargent, a dually qualified physician observed no large opacities consistent with pneumoconiosis on Claimant's x-rays, the Presiding Judge finds it questionable whether the large mass in Claimant's upper right lung is actually indicative of complicated pneumoconiosis. Moreover, the Presiding Judge notes that there is no general consensus among the physicians regarding whether Claimant has complicated pneumoconiosis. Accordingly, the Presiding Judge finds that Claimant has failed to prove by a preponderance of the x-ray evidence that he has complicated pneumoconiosis.

Turning next to the issue of whether Claimant has simple coal workers' pneumoconiosis, the Presiding Judge notes, as stated above, that review of all the x-ray evidence of record demonstrates that Claimant's simple coal workers' pneumoconiosis has progressed over the years. Specifically, after considering the qualifications of the physicians reading Claimant's x-rays, comparing the number of positive and negative readings for each x-ray, and comparing the number of positive and negative x-rays for each of Claimant's three claims, the Presiding Judge finds that (1) at the time Claimant filed his April 1, 1987 claim, his x-rays showed no abnormalities consistent with pneumoconiosis, (2) at the time Claimant filed his July 7, 1994 claim, his x-rays showed abnormalities consistent with category I simple pneumoconiosis, and (3) Claimant's x-rays from his current claim reveal abnormalities consistent with category II simple pneumoconiosis. Accordingly, in light of the foregoing, the Presiding Judge finds that Claimant has proven by a preponderance of the x-ray evidence that he has category II simple pneumoconiosis.

In this case, the Presiding Judge also finds that Claimant has also proven that his pneumoconiosis arose out of his coal mine employment. As previously discussed, because Claimant worked as a coal miner for more than ten years, in the absence of evidence to the contrary, it is presumed that Claimant's pneumoconiosis arose out of his coal mine employment. After reviewing the record, the Presiding Judge finds that there is no evidence that Claimant's clinical pneumoconiosis did not arise out of his coal mine employment. Accordingly, the Presiding Judge finds that Claimant has proven by a preponderance of the x-ray evidence that he suffers from clinical pneumoconiosis due to coal mine employment.

Biopsy

Pursuant to 20 C.F.R. § 718.202(a)(2), pneumoconiosis may be established through biopsy evidence, which is submitted in accordance with the quality standards set forth in 20 C.F.R. § 718.106 of the regulations. Notably, the quality standards state that a "negative biopsy is not conclusive evidence that the miner does not have pneumoconiosis," and that "where positive findings are obtained on biopsy, the results will constitute evidence of the presence of pneumoconiosis." 20 C.F.R. § 718.202(a)(2). On the other hand, 20 C.F.R. § 718.202(a)(2) specifically states that a finding of anthracotic pigmentation, by itself, is not sufficient to establish the existence of pneumoconiosis.

In this case, several physicians reviewed the biopsy evidence. Dr. Bella, analyzed biopsy specimens collected on February 24, 1988 and June 22, 1988. As previously summarized, upon reviewing the February 25, 1988 specimens, Dr. Bella found evidence of anthracotic pigments, nodular configuration, fibrosis, marked anthracotic figures and polarizing silicone particles, and inflammatory cells. Based on the foregoing, Dr. Bella diagnosed mild fibrosis and focal edema; anthracosilicosis, a few inflammatory cells, pulmonary histiocytes and anthracotic pigments, and no malignancy. Based on review of the June 22, 1988 specimens, Dr. Bella diagnosed fibrosis and chronic inflammation.

Dr. Crouch, who microscopically reviewed slides of the June 22, 1988 specimens noted in his report dated April 19, 1995, that he observed very mild nonspecific interstitial fibrosis and chronic inflammation, increased numbers of airspace macrophages, black core ferruginous bodies, and that parenchyma and intraalveolar macrophages contained moderate amounts of irregular to angulated black particles consistent with coal dust. Dr. Crouch further noted that, while he observed definite evidence of coal dust, he did not identify any lesions associated with coal worker's pneumoconiosis. Dr. Crouch concluded that, due to the limited amount of tissue examined, he could not definitively assess whether Claimant had pneumoconiosis or whether coal dust exposure contributed to any pulmonary disability Claimant had.

In a report dated, January 12, 1996, Dr. Caffrey noted that based on examination of the February 24, 1988 slides, he found a mild amount of anthracotic pigment within alveoli, although the specimens were negative for coal workers' pneumoconiosis or any other occupational pneumoconiosis. Dr. Caffrey further found, based on examination of the June 22, 1988 slides, a mild amount of anthracotic pigment and possible, minimal interstitial fibrosis, focal, and moderate, chronic inflammation. In his report, Dr. Caffrey mentioned several times that the tissue samples were extremely sparse. Dr. Caffrey, after also considering other evidence, concluded that Claimant did not have coal workers' pneumoconiosis or any other occupational pneumoconiosis.

Dr. Hutchins, who also microscopically examined the February 24, 1988 and June 22, 1988 specimens, noted in a report dated January 28, 1996 that the February 24, 1988 slides contained respiratory parenchyma and showed "a moderate amount of anthracotic pigment with associated birefringent silicate-type particles in perivascular and peribronchial tissues and within

macrophages within airspaces, although no macules, micronodules, or macronodules of coal workers' pneumoconiosis were observed. On the other hand, like Drs. Crouch and Caffrey, Dr. Hutchins also noted that "only a small amount of lung tissue was demonstrated on these slides." Also like Dr. Caffrey, after considering other evidence, Dr. Hutchins concluded that Claimant did not have coal workers' pneumoconiosis.

The final biopsy report in evidence was written by Dr. Skelly on May 20, 2004. Dr. Skelly examined samples colleted on May 13, 2004. In his report, Dr. Skelly found fragments of alveolated lung parenchymal tissue with focal mild to moderate anthracotic pigment deposition and occasional macrophages, benign bronchial mucosa and submucosa with focal slight to mild chronic inflammation, and no malignant cells, fungal hyphae, or budding yeasts.

Based on the foregoing reports, the Presiding Judge finds that the preponderance of the biopsy evidence does not demonstrate that Claimant has coal workers' pneumoconiosis.[40] Although Dr. Bella diagnosed anthracosilicosis, none of the other physicians, two of whom are board-certified pathologists, who reviewed the same slides made that diagnosis. Moreover, although Dr. Crouch stated that he saw definite evidence of coal dust, he further stated that he could not offer a definitive assessment regarding whether Claimant in fact had coal workers' pneumoconiosis due to the small amount of tissue he examined. Also, although nonspecific fibrosis was observed by several of the physicians, none of the physicians observed any lesions specifically associated with coal workers' pneumoconiosis. Accordingly, because Claimant bears the burden of proof, the Presiding Judge finds that Claimant has not proven that he has pneumoconiosis by a preponderance of the biopsy evidence pursuant to 20 C.F.R. § 718.202(a)(2).

Operation of Presumption[41]

As previously discussed, the regulations provide for an irrebuttable presumption of total disability due to pneumoconiosis if a miner is suffering or suffered from a chronic dust disease of the lung which: (a) when diagnosed by x-ray, yields opacities greater than one centimeter in diameter that would be classified in Category A, B, or C; (b) when diagnosed by biopsy, yields massive lesions in the lung; or (c) when diagnosed by means other than x-ray or biopsy, yields findings which could reasonably be expected to yield the results described in (a) or (b) had diagnosis been made as therein described: provided, however, that acceptable medical procedures are used. 20 C.F.R. § 718.304.

As set forth earlier in this Decision, the Presiding Judge finds that the preponderance of the x-ray evidence in this case does not demonstrate that Claimant has complicated pneumoconiosis. Moreover, the biopsy evidence in this case does not show that Claimant has

[40] On the other hand, the Presiding Judge also notes that the findings of the physicians in this case are not *inconsistent* with a finding that Claimant has CWP. Specifically, all of the physicians in this case noted the presence of anthracotic pigment in at least some of the tissue samples collected from Claimant's lungs. Moreover, the Presiding Judge notes that Dr. Bella's examinations were not specifically performed in order to determine whether Claimant had CWP and that the statements by Drs. Crouch, Caffrey, and Hutchins raise a doubt as to whether the specimens examined by those physicians were adequate for the purpose of assessing whether Claimant has CWP.

[41] The presumptions contained at §§ 718.305 and 718.306 are inapplicable in this case. Accordingly, they will not be discussed further in this Decision.

massive lesions in his lungs. Furthermore, none of Claimant's claims contain evidence that Claimant was diagnosed with a chronic dust disease of the lung by other means yielding findings similar to either large opacities or massive lesions. As previously discussed, the x-rays and CT scan contained in the hospitalization and treatment records submitted as part of Claimant's current claim are not evidence that Claimant suffers from a chronic dust disease of the lung. Accordingly, the Presiding Judge finds that the preponderance of the x-ray, biopsy, and other evidence of record does not establish that Claimant has complicated pneumoconiosis and, therefore, further finds that Claimant is not entitled to invoke the 20 C.F.R. § 718.304 irrebuttable presumption that he is totally disabled due to pneumoconiosis. Moreover, because Claimant is not entitled to invoke the 20 C.F.R. § 718.304 irrebuttable presumption, he has failed to prove that he has pneumoconiosis pursuant to 718.202(a)(3).

Medical Opinions

The final method by which Claimant may establish that he suffers from pneumoconiosis is by well-reasoned, well-documented medical opinions rendered by physicians exercising sound medical judgment based on objective medical evidence, such as blood-gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. *See* 20 C.F.R. 718.202(a)(4). A "documented" opinion is one that sets forth the clinical findings, observations, facts and other data on which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's history. *See Hoffman v. B&G Construction Co.*, 8 B.L.R. 1-65 (1985); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295 (1984).

A "reasoned" opinion is one in which the administrative law judge finds the underlying documentation adequate to support the physician's conclusions. *Fields, supra*. Indeed, whether a medical opinion is sufficiently documented and reasoned is for the administrative law judge as the finder-of-fact to decide. *See Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989)(en banc). Moreover, legal pneumoconiosis is established by well-reasoned medical opinions, which support a finding that the miner's pulmonary or respiratory condition is significantly related to or substantially aggravated by coal dust exposure. *See Wilburn v. Director, OWCP*, 11 B.L.R. 1-135 (1988).

In weighing the opinions, more weight may be accorded to a medical report containing the most recent physical examination of the miner because it is likely to contain a more accurate evaluation of the miner's current condition. *Gillespie v. Badger Coal Co.*, 7 B.L.R. 1-839 (1985); *Bates v. Director, OWCP*, 7 B.L.R. 1-113 (1984); *Kendrick v. Kentland-Elkhorn Coal Co.*, 5 B.L.R. 1-730 (1983). Furthermore, an opinion which is better supported by the objective medical evidence of record may be accorded greater probative value, *Minnich v. Pagnotti Enterprises, Inc.*, 9 B.L.R. 1-89, 1-90 n.1 (1986); *Wetzel v. Director, OWCP*, 8 B.L.R. 1-139 (1985), and an opinion that provides no rationale and does not explain what evidence in the record supports the opinion may be discredited, *see Harkey v. Alabama By-Products Corp.*, 7 B.L.R. 1-26 (1984).

In this case, there are several physicians' opinions in the record. After thoroughly reviewing the reports and deposition testimony of the physicians, the Presiding Judge finds that, except as specifically noted herein, the opinions of the physicians, which are based on either thorough examination of Claimant or thorough review of the medical evidence, are well-documented. Moreover, the Presiding Judge also finds that, except as specifically noted herein, the opinions of the physicians are well-reasoned because the underlying evidence summarized in the opinions is adequate to support the physicians' conclusions. Accordingly, except as specifically stated herein, the adequacy of an opinion's documentation or reasoning was not a factor in weighing the evidence.

Opinions submitted as part of Claimant's April 1, 1987 claim

Dr. Anderson, who is board-certified in internal medicine and has a subspecialty in pulmonary disease, diagnosed Claimant with category I pneumoconiosis. He did not diagnose legal pneumoconiosis. Dr. Anderson opined that category I simple pneumoconiosis does not cause symptoms and that Claimant did not have a pulmonary impairment.

Dr. Martin, whose qualifications are unknown, diagnosed Claimant with category I pneumoconiosis. Dr. Martin did not address whether Claimant, at the time, had legal pneumoconiosis.

Dr. Wright, who is board certified in anesthesiology, found that category I pneumoconiosis could not be excluded. Moreover, in his original report, Dr. Wright found that Claimant suffered from a very mild obstructive airflow defect or small airways disease and that Claimant's coal mine employment was a contributing factor. On the other hand, in a supplemental report, although Dr. Wright stated that Claimant did have an occupational lung disease caused by his coal mine employment and that Claimant also had a mild pulmonary impairment, Dr. Wright attributed this impairment to smoking and tuberculosis. After reviewing Dr. Wright's opinions, the Presiding Judge finds that Dr. Wright's later opinion in his supplemental report is not well-reasoned. Dr. Wright's supplemental report provides no explanation for why he changed his opinion. Moreover, Dr. Wright provides no rationale explaining how, in light of his earlier statement that it was impossible to determine what part of Claimant's impairment was due to dust exposure and what part was due to smoking, he was able to conclude that coal dust exposure did not contribute to Claimant's impairment. Accordingly, Dr. Wright's later opinion is accorded little probative value.

Dr. Penman, who is board-certified in internal medicine with a subspecialty in pulmonary disease, diagnosed Claimant with category I pneumoconiosis. Dr. Penman also found that Claimant suffered from hypoxia, caused at least in part by pneumoconiosis, and stated that Claimant had chronic bronchitis, caused at least in part by chronic exposure to coal and rock dust.

Dr. Broudy, who is a B-reader and board-certified in internal medicine with a subspecialty in pulmonary disease, opined that Claimant did not have pneumoconiosis. He opined that Claimant's restrictive ventilatory defect could be due to Claimant's previous lung surgery and partial lung resection. Dr. Broudy did not provide any rationale for his opinion or

address other possible factors, including Claimant's history of coal dust exposure, that were evident from Claimant's history, that could have contributed to Claimant's restrictive ventilatory defect. Therefore, the Presiding Judge finds that Dr. Broudy's opinion, regarding the cause of Claimant's ventilatory defect, is not well-reasoned and accords it little probative value.

Dr. Williams, whose qualifications are unknown, found that Claimant suffered from category 0/1 pneumoconiosis and diagnosed chronic obstructive pulmonary disease, which he opined was due to Claimant's left lower lobectomy. With regard to Dr. Williams' diagnosis of category 0/1 clinical pneumoconiosis, the Presiding Judge notes that the minimum classification which can qualify as a diagnosis of clinical pneumoconiosis is 1/0. Therefore Dr. Williams' opinion that Claimant has clinical pneumoconiosis is accorded no weight. Moreover, with regard to Dr. Williams' opinion regarding Claimant's chronic obstructive pulmonary disease, the Presiding Judge notes that Dr. Williams, like Dr. Broudy, did not provide any rationale for why he believed other factors, such as smoking or coal dust exposure, did not contribute to Claimant's impairment. Accordingly, the Presiding Judge finds that Dr. Williams' opinion, regarding the cause of Claimant's pulmonary impairment, is not well-reasoned and is accorded little probative value.

Dr. Lane, who is a B-reader and board-certified in internal medicine, opined that Claimant did not have pneumoconiosis. Dr. Lane also found that, at the time, Claimant did not suffer from any pulmonary impairment.

Dr. Harrison, who is a B-reader and board-certified in internal medicine with a subspecialty in pulmonary disease, opined that Claimant did not have pneumoconiosis. Instead, Dr. Harrison opined that Claimant's symptoms were caused by bullous emphysema, which he felt was not related to Claimant's coal mine employment. Dr. Harrison also opined that Claimant could have a congenital defect. Upon review of Dr. Harrison's report, the Presiding Judge finds that Dr. Harrison provided no rationale explaining how he determined that Claimant's bullous emphysema was not caused, even in part, by Claimant's previous coal mine employment or other potential contributing factors disclosed by Claimant's medical history. Accordingly, the Presiding Judge finds that Dr. Harrison's opinion, regarding the cause of Claimant's bullous emphysema, is not well-reasoned and accords it little probative value.

Opinions submitted as part of Claimant's July 7, 1994 claim

Dr. Baker, who is a B-reader and whose other qualifications at the time are unknown, diagnosed Claimant with either category II pneumoconiosis or tuberculosis, which he said was caused by either tuberculosis or coal mine employment. Dr. Baker also opined that Claimant suffered from chronic obstructive pulmonary disease ("COPD") with mild defect and chronic bronchitis caused by Claimant's cigarette smoking and coal mine employment. On the other hand, Dr. Baker provided no rationale for why he was able to exclude Claimant's prior lung resection as a contributing factor of Claimant's COPD and chronic bronchitis. Accordingly, the Presiding Judge finds that Dr. Baker's opinion regarding the cause of Claimant COPD and chronic bronchitis is not well-reasoned and is accorded little weight. Moreover, the Presiding Judge finds Dr. Baker's opinion regarding whether Claimant has clinical pneumoconiosis to be

equivocal and, therefore, finds that it is not entitled to much weight. *Island Creek Coal Co. v. Holdman*, 202 F.3d 873 (6th Cir. 2000).

Dr. Broudy, who is a B-reader and board-certified in internal medicine with a subspecialty in pulmonary disease, noted that Claimant's x-ray showed abnormalities consistent with category II pneumoconiosis but questioned whether the abnormalities actually represented another disease process. Dr. Broudy noted that it was unusual for evidence of pneumoconiosis to first appear only after a miner quit working in the mines and that the degree of progression in seven years was quite unusual. Dr. Broudy also diagnosed chronic bronchitis with mild chronic obstructive airways disease, which he attributed to smoking. After reviewing Dr. Broudy's report, the Presiding Judge finds that his opinion regarding the cause of Claimant's chronic bronchitis and mild chronic obstructive airways disease is not well-reasoned because Dr. Broudy provides no rationale how he formulated his opinion or on what evidence he relied. Accordingly, Dr. Broudy's opinion, regarding the cause of Claimant's pulmonary impairments, is accorded little weight.

Dr. Wright, who is board-certified in anesthesiology, opined that clinical category I pneumoconiosis could not be excluded. Furthermore, although Dr. Wright found that Claimant had a mild pulmonary impairment, Dr. Wright opined that it was due to Claimant's past smoking habit. Specifically, Dr. Wright diagnosed Claimant with chronic smokers' bronchitis, with mild to moderate functional impairment. Dr. Wright provided no explanation in his report for how he was able to exclude coal dust and Claimant's lung resection as contributing factors to Claimant's pulmonary impairment. Accordingly, the Presiding Judge finds Dr. Wright's opinion regarding the cause of Claimant's mild pulmonary impairment to be not well-reasoned and accords it little weight.

Dr. Caffrey, who is a board-certified pathologist, opined that Claimant did not have pneumoconiosis. Dr. Caffrey based his opinion in part on his belief that pneumoconiosis did not progress after a miner quit working in the mines and his observation that Claimant apparently did not exhibit abnormalities consistent with the disease on x-rays taken shortly after he retired. Although Dr. Caffrey noted that Claimant, at the time, was manifesting symptoms consistent with pneumoconiosis, Dr. Caffrey did not attribute these symptoms to Claimant's coal mine employment. Specifically, while Dr. Caffrey noted that, according to Dr. Broudy, Claimant had chronic bronchitis, Dr. Caffrey further noted that Dr. Broudy attributed this condition to smoking. Dr. Caffrey also noted that Claimant did not have a significant pulmonary disability and stated that Claimant's pacemaker, tuberculosis, and histoplasmosis were not related to Claimant's work as a coal miner. After reviewing Dr. Caffrey's report, the Presiding Judge finds Dr. Caffrey's opinion that Claimant's dust exposure causes him no pulmonary disability and his opinion that Claimant does not have clinical pneumoconiosis to be unreliable. The Presiding Judge notes that these opinions are based, in large part, on a belief that is contrary to the regulations, which state that pneumoconiosis is a progressive and latent disease. Moreover, Dr. Caffrey accepted as accurate Dr. Broudy's opinion regarding the cause of Claimant's chronic bronchitis. Yet, as previously stated, the Presiding Judge finds Dr. Broudy's opinion to not be well-reasoned. Accordingly, Dr. Caffrey's opinion is given little weight.

Dr. Hutchins, who is a board-certified pathologist, opined that claimant does not have clinical pneumoconiosis. Dr. Hutchins offered no opinion regarding whether Claimant has legal pneumoconiosis.

Dr. Branscomb, who is a B-reader, is board-certified in internal medicine, and has extensive experience in the field of pulmonary medicine, opined that Claimant did not have clinical pneumoconiosis. Dr. Branscomb also found that Claimant appeared to have mild chronic bronchitis and mild expiratory obstruction, which he attributed to Claimant's cigarette smoking. Dr. Branscomb did not provide an explanation for how he was able to determine that coal dust exposure was not a contributing factor in Claimant's pulmonary impairments. Accordingly, the Presiding Judge finds that Dr. Branscomb's opinion regarding the cause of Claimant's pulmonary impairments is not well-reasoned and therefore is accorded little weight.

Opinions submitted as part of Claimant's November 4, 2002 claim

Dr. Baker, who is a B-reader and board-certified in internal medicine with a subspecialty in pulmonary disease, diagnosed Claimant with clinical category I pneumoconiosis, chronic bronchitis, and COPD with mild obstructive defect. Dr. Baker opined that Claimant's clinical pneumoconiosis was due to coal dust exposure, although he questioned whether the abnormalities he viewed on Claimant's x-ray were secondary to tuberculosis. With regard to his diagnoses of chronic bronchitis and COPD, Dr. Baker opined that these conditions were caused by Claimant's cigarette smoking and exposure to coal mine dust. At his deposition, Dr. Baker provided a rationale for why he did not opine that Claimant's pulmonary impairments were caused by Claimant's lung resection.

Dr. Dahhan, who is a B-reader and board-certified in internal medicine with a subspecialty in pulmonary disease, diagnosed clinical category I pneumoconiosis, which he stated in his deposition was caused by the inhalation of coal dust. Dr. Dahhan did not diagnose legal pneumoconiosis. Although he noted that Claimant had a mild ventilatory impairment based on Claimant's pulmonary function study values, he attributed the impairment to Claimant's lung resection and smoking. Dr. Dahhan stated that he felt smoking affected Claimant's lung function by causing him to develop bronchitis. On the other hand, Dr. Dahhan stated that he was not able to diagnose chronic bronchitis because, although Claimant had a history of symptoms consistent with chronic bronchitis, he also had a history of tuberculosis. Moreover, Dr. Dahhan also stated that coal dust exposure can cause bronchitis. Although Dr. Dahhan stated that, based on epidemiological function, he would only estimate that around 100 cc's of Claimant's obstructive airway disease was due to coal dust, he acknowledged that the actual effect of coal dust exposure on an individual's FEV_1 value could be greater than the function predicted. Additionally, Dr. Dahhan also acknowledged that not all smokers suffer a deficit in their FEV_1 values and that it was not possible to know whether Claimant's FEV_1 deficit was caused by smoking. In reviewing Dr. Dahhan's report and deposition testimony, the Presiding Judge finds Dr. Dahhan's opinions regarding the effect of smoking and coal dust on Claimant's pulmonary function and whether Claimant has chronic bronchitis or whether his symptoms represent some other disease process to be equivocal and internally inconsistent. Moreover, Dr. Dahhan's opinions are also not well-reasoned. Dr. Dahhan based his opinions on the fact that Claimant has a history of tuberculosis, even though he acknowledged that he did not know whether Claimant had active

tuberculosis and there was no evidence that Claimant had suffered from an active tuberculosis or similar infection since Claimant filed his second claim. Accordingly, in light of the foregoing and the fact that Claimant's symptoms could realistically be caused by another condition, the Presiding Judge finds Dr. Dahhan's explanation that he attributed Claimant's symptoms to tuberculosis rather than chronic bronchitis merely because Claimant had a history of tuberculosis to be inadequate. Therefore, Dr. Dahhan's opinion is accorded little weight.

Dr. Fino, who is a B-reader and board-certified in internal medicine with a subspecialty in pulmonary disease, opined that Claimant did not have pneumoconiosis. Although Dr. Fino found that Claimant had a combined obstructive and restrictive ventilatory abnormality, he opined that this impairment was caused by significant lung scarring due to old tuberculosis. Specifically, Dr. Fino opined that the restrictive abnormality was caused by lung resection and significant scaring and that the obstructive abnormality was consistent with tuberculosis. Dr. Fino noted that tuberculosis, such as that suffered by Claimant could cause bronchiectasis, which results in an obstructive abnormality. Dr. Fino further stated that he believed Claimant's smoking and dust exposures were clinically insignificant. After reviewing Dr. Fino's report, the Presiding Judge finds that the underlying evidence summarized in Dr. Fino's report is inadequate to support Dr. Fino's opinions regarding the cause of Claimant's restrictive and obstructive abnormalities. The Presiding Judge notes that Dr. Fino did not provide any rationale explaining why he found Claimant's smoking and dust exposure histories to be clinically insignificant. Moreover, with regard to Dr. Fino's rationale for why Claimant's obstructive abnormality is consistent with tuberculosis, the Presiding Judge notes that, elsewhere in his report, Dr. Fino wrote that Claimant did not have a history of bronchiectasis and that Dr. Fino provided no rationale explaining why he rejected this evidence. Accordingly, the Presiding Judge finds that Dr. Fino's opinions regarding the causes of Claimant's pulmonary impairments are not well-reasoned.

Based on a review of the well-reasoned medical judgments rendered in this case, the Presiding Judge finds that the preponderance of the medical opinion evidence establishes that Claimant currently has clinical and legal pneumoconiosis. In weighing the opinions, the Presiding Judge notes that, in general, the most weight was accorded to the opinions of Drs. Baker, Dahhan, and Fino, who most recently evaluated Claimant. Moreover, more weight was accorded to the opinions from Claimant's July 7, 1994 claim than the opinions from Claimant's April 1, 1987 claim. Furthermore, in weighing the opinions, the Presiding Judge notes that more weight was also accorded to opinions rendered by physicians with superior qualifications.

Turning first to the matter of whether Claimant has clinical pneumoconiosis, the Presiding Judge notes that eight physicians diagnosed clinical pneumoconiosis while six opined that Claimant did not have the disease. Moreover, while the Presiding Judge notes that five of these negative opinions were rendered by B-readers, the Presiding Judge further notes that three of those opinions were rendered as part of Claimant's April 1, 1987 claim. Accordingly, when only the opinions rendered in Claimant's second and current claims are considered, four physicians, three of whom are B-readers, diagnosed clinical pneumoconiosis, while three physicians, two of whom are B-readers, found no evidence of the disease. Moreover, consideration of only the opinions submitted as part of Claimant's current claim produces a similar outcome: two physicians, both B-readers, diagnosed clinical pneumoconiosis, while one

physician, also a B-reader, did not diagnose the disease. Accordingly, based on the foregoing evidence, the Presiding Judge finds that the preponderance of the medical opinion evidence demonstrates that Claimant has clinical pneumoconiosis. In making this finding, the Presiding Judge notes that while several physicians acknowledged that the abnormalities on Claimant's x-rays could have been caused by another disease process, the physicians' diagnoses of clinical pneumoconiosis are consistent with the overall evidence of record, e.g. the x-ray evidence of record, Claimant's medical records, and the biopsy evidence. Accordingly, the mere possibility that the x-ray abnormalities could be due to some other disease process, alone, is insufficient to rebut the opinion evidence of record, which establishes that Claimant has clinical pneumoconiosis.

Next, turning to the matter of whether Claimant has legal pneumoconiosis, the Presiding Judge notes that there is general agreement among the physicians, who considered whether Claimant has legal pneumoconiosis, that Claimant has a pulmonary impairment: Dr. Wright diagnosed a very mild obstructive airflow defect or small airways disease in 1986 and chronic smokers' bronchitis in 1995; Dr. Penman diagnosed hypoxia and stated that Claimant had a history consistent with chronic bronchitis; Dr. Broudy diagnosed a restrictive ventilatory defect in 1987 and chronic bronchitis with mild chronic obstructive airways disease in 1994; Dr. Williams diagnosed chronic obstructive pulmonary disease; Dr. Harrison diagnosed bullous emphysema; Dr. Baker diagnosed chronic bronchitis and chronic obstructive pulmonary disease; Dr. Caffrey noted that Claimant had been diagnosed with chronic bronchitis; Dr. Branscomb diagnosed mild chronic bronchitis and mild expiratory obstruction; Dr. Dahhan diagnosed a mild ventilatory impairment and stated that Claimant's history of symptoms was consistent with chronic bronchitis, although he did not diagnose the condition; and Dr. Fino diagnosed a combined restrictive and obstructive ventilatory abnormality. Overall, in this case, only Drs. Anderson and Lane, who evaluated Claimant in 1986 and 1987, found that Claimant did not suffer from any pulmonary impairment. Moreover, of the ten physicians' who determined that Claimant suffers from a pulmonary impairment, five (Dr. Wright, Dr. Broudy, Dr. Williams, Dr. Baker, and Dr. Branscomb) diagnosed a chronic lung disease or impairment while three other physicians (Dr. Penman, Dr. Caffrey, and Dr. Dahhan) noted either that Claimant's medical history was consistent with chronic bronchitis or that Claimant had been diagnosed with the condition. Accordingly, the Presiding Judge finds that the preponderance of the medical opinion evidence establishes that Claimant suffers from a chronic lung disease or impairment. As a result, the remaining issue to be decided is whether Claimant's chronic lung disease or impairment is in fact substantially related to Claimant's coal mine employment.

In this case, only two of the physicians who either diagnosed or found Claimant's medical history to be consistent with a chronic lung disease or impairment offered well-reasoned medical opinions regarding the cause of Claimant's condition. Drs. Penman and Baker, who are both board-certified in internal medicine and have subspecialties in pulmonary disease, opined that coal dust exposure contributed to Claimant's pulmonary impairment. Accordingly, after reviewing the opinions by Dr. Wright, Dr. Broudy, Dr. Williams, Dr. Caffrey, Dr. Branscomb, and Dr. Dahhan, which attribute Claimant's impairment to a cause other than coal mine dust and which the Presiding Judge found to be not well-reasoned, the Presiding Judge finds that controlling weight in this instance should be accorded to the opinions of Drs. Penman and Baker. Although the Presiding Judge notes that three of these six physicians are highly qualified, the

Presiding Judge still finds these opinions to be insufficient evidence to rebut the well-reasoned opinions of Drs. Penman and Baker. Specifically, while the opinions certainly provide evidence that factors other than coal dust contributed to Claimant's pulmonary disability, the opinions are insufficient to prove that coal dust was not, at least in part, also a contributing factor. As a result, the Presiding Judge finds that Claimant has proven by a preponderance of the medical opinion evidence that he has legal pneumoconiosis.

Moreover, in this case, as previously discussed, because Claimant worked for at least ten years as a coal miner, Claimant is entitled to the rebuttable presumption that his pneumoconiosis arose out of his coal mine employment. After reviewing the medical opinion evidence and other evidence of record the Presiding Judge finds that there is no evidence that either Claimant's legal or clinical pneumoconiosis are not due, at least in part, to Claimant's coal mine employment. Accordingly, the Presiding Judge finds that Claimant has proven by a preponderance of the evidence that he has both clinical and legal pneumoconiosis which arose out of his coal mine employment.

B. Element 3: Total Disability

As previously discussed, the Presiding Judge found that Claimant has proven, by a preponderance of the new evidence submitted in this case, that he is totally disabled. Upon reviewing all evidence in the record, the Presiding Judge continues to find that Claimant has satisfied his burden with regard to this element. The Presiding Judge notes that, in determining whether Claimant is now entitled to benefits, the Presiding Judge must consider whether Claimant is *currently* totally disabled. Although the Presiding Judge notes that the preponderance of the evidence from Claimant's prior claims demonstrates that Claimant was not totally disabled in the late 1980's or the mid 1990's, this evidence has very little probative value or relevance with regard to whether Claimant is now totally disabled. *Gillespie v. Badger Coal Co.*, 7 B.L.R. 1-839 (1985); *Bates v. Director, OWCP*, 7 B.L.R. 1-113 (1984); *Kendrick v. Kentland-Elkhorn Coal Co.*, 5 B.L.R. 1-730 (1983). Moreover, review of the entire record reveals that Claimant's pulmonary health has declined since his last claim was adjudicated. Accordingly, the Presiding Judge finds that the evidence from Claimant's prior claims does not accurately reflect Claimant's current level of disability. As a result, as stated above, the Presiding Judge continues to find that Claimant has proven by a preponderance of the evidence that he is totally disabled.

C. Element 4: Establishing Total Disability Due to Pneumoconiosis

A miner must establish that the miner's pneumoconiosis is a "substantially contributing cause" of the miner's total disability. 20 C.F.R. § 718.204(c)(1). The regulations define "substantially contributing cause" as follows:

> (i) Has a material adverse effect on the miner's respiratory or pulmonary condition; or

(ii) Materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment.

20 C.F.R. § 718.204(c)(1); *see Tennessee Consolidated Coal Co. v. Kirk*, 264 F.3d 602 (6th Cir. 2001). Moreover, the regulations provide that the cause or causes of a miner's total disability shall be established by means of "a physician's documented and reasoned medical report."[42] 20 C.F.R. § 718.204(c)(2). In this case, none of the physicians who offered opinions in either of Claimant's prior claims found that Claimant was totally disabled and the evidence of record establishes that Claimant's respiratory health has declined since the adjudication of Claimant's last claim, which was filed on July 7, 1994. Accordingly, the Presiding Judge finds that, under the circumstances, the physicians' opinions from Claimant's two prior claims are of little probative for the purpose of determining whether Claimant's pneumoconiosis is a substantial cause of his total disability. *Gillespie v. Badger Coal Co.*, 7 B.L.R. 1-839 (1985); *Bates v. Director, OWCP*, 7 B.L.R. 1-113 (1984); *Kendrick v. Kentland-Elkhorn Coal Co.*, 5 B.L.R. 1-730 (1983). As a result, the Presiding Judge places substantial weight on the opinions of Dr. Baker, Dr. Dahhan, and Dr. Fino, who are all board-certified in internal medicine with a subspecialty in pulmonary disease and who most recently examined the Claimant in this case.

Turning first to Dr. Baker's opinion, the Presiding Judge notes that Dr. Baker opined that Claimant's impairment was fully caused by Claimant's pneumoconiosis, chronic bronchitis, chronic obstructive pulmonary disease, old pulmonary tuberculosis, and sick sinus syndrome. Dr. Baker stated that Claimant's impairment encompassed Claimant's decreased FEV_1, chronic bronchitis and coal workers' pneumoconiosis 1/0. Moreover, Dr. Baker stated that when he considered the lengths of Claimant's smoking and dust exposure histories, he found that at least fifty percent of Claimant's condition was attributable to Claimant's coal mine employment. After reviewing Dr. Baker's report, deposition testimony, and the evidence of record, the Presiding Judge finds that Dr. Baker's opinion is well-documented and well-reasoned and accords it full weight.

Now turning to Dr. Dahhan's opinion, as previously discussed, Dr. Dahhan opined that Claimant's ventilatory impairment was primarily caused by Claimant's lung resection. Dr. Dahhan stated that Claimant had between twenty and twenty-five percent of his lungs removed in the late 1960's and therefore calculated that the resection resulted in approximately a twenty percent decrease in Claimant's FEV_1 value. Yet, in this case, the evidence establishes that Claimant's pulmonary disability has progressed over time. Accordingly, although Claimant's lung resection may explain the decrease in pulmonary function values observed in the studies from Claimant's April 1, 1987 claim, Claimant's surgery does not account for the further decrease in Claimant's pulmonary function values that occurred thereafter.

In his medical report, Dr. Dahhan also opined that Claimant's ventilatory impairment was in part due to Claimant's smoking habit, which he thought caused Claimant to develop bronchitis. On the other hand, Dr. Dahhan stated that he did not diagnose chronic bronchitis

[42] The following exceptions are permitted under 20 C.F.R. § 718.204(c)(2): cases where the presumption prescribed in 20 C.F.R. § 718.305 is applicable; cases where total disability is established by proving the miner suffered from cor pulmonale with right-sided congestive heart failure as set forth in 20 C.F.R. § 718.204(b)(iii); and in certain circumstances where causation may be proven by lay testimony as set forth in 20 C.F.R. § 718.204(d).

because Claimant had a history of tuberculosis, which could cause the same symptoms. Yet, in this case, Dr. Dahhan did not know if Claimant had active tuberculosis and had no evidence that Claimant had suffered from either active tuberculosis or a similar disease subsequent to the filing of his second claim. Moreover, although Dr. Dahhan apparently did not find coal dust to be a substantially contributing factor of Claimant's obstructive airways disease, based on epidemiological function, Dr. Dahhan stated that the exact mechanism for how coal dust exposure causes COPD is not known and that it could cause bronchitis. Dr. Dahhan also acknowledged that not all smokers suffer a deficit in their FEV_1 values and that it was not possible to know whether Claimant's FEV_1 deficit was caused by smoking. Dr. Dahhan further acknowledged that the deficit in Claimant's FEV_1 value caused by smoking could be smaller and the deficit caused by coal dust exposure could be larger than he predicted.

Lastly, Dr. Dahhan also stated in his deposition that he found no evidence that any of Claimant's reduced ventilatory capacity was due to Claimant's coal workers' pneumoconiosis. Yet, Dr. Dahhan provides no rationale explaining this broad and vague conclusion or how he was able to distinguish this potential cause of Claimant's ventilatory impairment from other contributing factors.

Accordingly, based on the foregoing analysis and review of the evidence of record, the Presiding Judge finds that Dr. Dahhan's opinion should be accorded less weight. Specifically, the Presiding Judge finds Dr. Dahhan's opinion to be internally inconsistent, not well-reasoned, and not supported by the evidence of record. Moreover, Dr. Dahhan's opinion is contrary to the Presiding Judge's finding that Claimant suffers from legal pneumoconiosis.[43] *Skukan v. Consolidation Coal Co.*, 993 F.2d 1228, 17 B.L.R. 2-97 (6th Cir. 1993), vacated on other grounds, 512 U.S. 1231 (1994); *Abshire v. D&L Coal Co.*, 22 B.L.R. 1-202 (2002) (en banc).

Turning now to Dr. Fino's opinion, the Presiding Judge notes that Dr. Fino found that Claimant has a combined obstructive and restrictive ventilatory abnormality, which he opined was caused by resection of Claimant's lung and significant lung scarring due to old tuberculosis. Although Dr. Fino wrote that he could not definitively rule out coal dust exposure and smoking as contributing factors of Claimant's impairment, he felt that these exposures were not clinically significant. Yet, Dr. Fino provides no explanation for this conclusion. Moreover, in this case, as in the case with Dr. Dahhan, Dr. Fino's conclusion that Claimant's total disability is caused by resection of Claimant's lung and significant lung scarring due to old tuberculosis, does not account for all of Claimant's pulmonary disability, as revealed by the evidence of record. Again, the Presiding Judge notes that Claimant's lung resection occurred in 1968 and that there is no evidence that Claimant has suffered from either active tuberculosis or a similar disease subsequent to the filing of Claimant's second claim. Moreover, also as previously noted, the evidence of record establishes that Claimant's pulmonary disability has progressed over time. Accordingly, the Presiding Judge finds that Dr. Fino's opinion does not provide an adequate explanation for Claimant's pulmonary disability and is not well-reasoned. Furthermore, as previously discussed, Dr. Fino's opinion is also internally inconsistent. In his report, Dr. Fino rationalized his conclusion that Claimant's obstructive abnormality was caused by tuberculosis, by stating that tuberculosis could cause bronchiectasis, which results in an obstructive

[43] While the Presiding Judge notes that Dr. Dahhan diagnosed Claimant with clinical pneumoconiosis, the Presiding Judge also notes that legal pneumoconiosis is a broader category than clinical pneumoconiosis.

abnormality, even though Dr. Fino wrote in his report that Claimant does not have a history of bronchiectasis. Notably, Dr. Fino provides no explanation in his report that reconciles this conflict. Moreover, like Dr. Dahhan's opinion, Dr. Fino's opinion is contrary to the Presiding Judge's finding that Claimant suffers from legal pneumoconiosis. Accordingly, for the foregoing reasons, the Presiding Judge finds that Dr. Fino's report is entitled to less weight.

In considering the opinions of Dr. Baker, Dr. Dahhan, and Dr. Fino, in light of the foregoing analysis, the Presiding Judge finds that the preponderance of the new medical opinion evidence of record, to which he accords significant weight, establishes that Claimant's total disability is substantially due to pneumoconiosis. Moreover, in considering the medical opinions from Claimant's prior claims, the Presiding Judge finds that Dr. Baker's opinion outweighs the opinions of the physicians in this case who did not opine that Claimant is totally disabled and evaluated Claimant seven or more years before he filed his current claim. Accordingly, the Presiding Judge finds that Claimant has proven by a preponderance of the evidence that his total disability is due to pneumoconiosis.

D. Conclusion

Based on a thorough review of all evidence presented in this case, the Presiding Judge finds that the preponderance of the evidence demonstrates that Claimant has both clinical and legal pneumoconiosis arising out of his coal mine employment and that Claimant is totally disabled due to that pneumoconiosis. In this case, Claimant established by a preponderance of the x-ray and medical opinion evidence, which is consistent with the other evidence of record, that he has pneumoconiosis arising out of his coal mine employment. Moreover, Claimant proved by a preponderance of the medical opinion evidence that he is totally disabled and that his disability is due to pneumoconiosis. Accordingly, Claimant has established all the elements of entitled in his claim and is therefore entitled to benefits under the Act.

Entitlement

Claimant is entitled to benefits beginning in the month he became totally disabled due to pneumoconiosis or, if such a date cannot be determined from the record, the month in which the miner filed his claim which, in this case, is November 2002. 20 C.F.R. § 725.503(b); *Owens v. Jewell Smokeless Coal Corp.*, 14 B.L.R. 1-47 (1990). Moreover, it is noteworthy that the date of the first medical evidence of record indicating total disability does not establish the onset date; rather, such evidence only indicates that the miner became totally disabled at some prior point in time. *Tobrey v. Director, OWCP*, 7 B.L.R. 1-407, 1-409 (1984).

Upon review of the record in this case, the Presiding Judge finds that the onset date cannot be determined from the medical evidence and, therefore, benefits are payable from November 2002, the month in which the miner's claim was filed. Moreover, as the parties have stipulated that Claimant has one dependent, his wife, Claimant is also entitled to augmentation of his award of benefits on behalf of his spouse.

ORDER

For the reasons set forth in the foregoing discussion, IT IS ORDERED that the claim for benefits filed by B.S. is **GRANTED** and the payment of benefits shall commence as of November 1, 2002.

IT IS FURTHER ORDERED that, within 30 DAYS of the date of issuance of this Decision, Claimant's counsel shall file, with this Office and with opposing counsel, a petition for a representatives' fees and costs in accordance with the regulatory requirements set forth at 20 C.F.R. § 725.366. Counsel for the Director and for Employer shall file any objections with this Office and with Claimant's counsel within 20 DAYS of receipt of the petition for fees and costs. It is requested that the petition for services and costs CLEARLY provide (1) counsel's hourly rate with supporting argument or documentation, (2) a clear itemization of the complexity and type of services rendered, and (3) that the petition contain a request for payment for services rendered and costs incurred before this Office ONLY as the undersigned does not have authority to adjudicate fee petitions for work performed before the district director or appellate tribunals. *Ilkewicz v. Director, OWCP*, 4 B.L.R. 1-400 (1982).

A

Daniel A. Sarno, Jr.
Administrative Law Judge

DAS/mam

NOTICE OF APPEAL RIGHTS

If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. See 20 C.F.R. §§ 725.478 and 725.479. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. See 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed. At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. See 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision